Naples Women's Center
1726 Medical Blvd., Suite 101
Naples, FL 34110-1426
Phone: (239) 513-1992
Fax: (239) 513-9022

DATE _____

NAME _____
LAST FIRST MIDDLE

IO# _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTHDATE AGE RACE MARITALSTATUS S M W D SEP

ADDRESS

OCCUPATION
☐ HOMEMAKER
☐ OUTSIDE WORK
☐ STUDENT Type of Work

EDUCATION (LAST GRADE COMPLETED)

ZIP PHONE (H) (O)

INSURANCE CARRIER/MEDICAID

HUSBAND/FATHER OF BABY PHONE

EMERGENCY CONTACT PHONE

TOTAL PREG	FULLTERM	PREMATURE	AB INDUCED	AB SPONTANEOUS	MULTIPLE BIRTHS	ECTOPICS	LIVING

MENSTRUAL HISTORY

LM ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENES MONTHLY ☐ YES ☐ NO FREQUENCY: ____ DAYS MENARCH _____ (AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT / DURATION PRIOR MENES _____ DATE ONBCPATCONCEPT. ☐ YES ☐ NO
☐ FINAL _____ HCG+ ____ / ____ / ____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENTGH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	PLACEOF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

PAST MEDICAL HISTORY

	ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1.DIABETES		
2.HYPERTENSION		
3.HEART DISEASE		
4.AUTO IMMUNE DISORDER		
5.KIDNEY DISEASE/UTI		
6.NEUROLOGIC/EPILEPSY		
7.PSYCHIATRIC		
8.HEPATITIS/LIVER DISEASE		
9.VARICOSITIES/PHLEBITIS		
10.THYROID DYSFUNCTION		
11.TRAUMA/DOMESTIC VIOLENCE		
12.HISTORY OF BLOOD TRANSFS		

	AMT/DAY PRE-PREG	AMT/DAY PRE-PREG	#YEARS USE
13.TOBACCO			
14.ALCOHOL			
15.STREET DRUGS			

	ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
16.O(Rh) SENSITIZED		
17.PULMONARY (TB,ASTHMA)		
18.ALLERGIES (DRUGS)		
19.BREAST		
20.GYN SURGERY		
21.OPERATION/HOSPITALIZATIONS (YEAR & REASON)		
22.ANESTHETIC COMPLICATIONS		
23.HISTORY OF ABNORMAL PAP		
24.UTERINE ANOMALY / DES		
25.INFERTILITY		
26.RELEVANT FAMILY HISTORY		
27.OTHER		

COMMENTS _____

EXPOSURES AFFECTING HEALTH

1 ☐ YES ☐ NO DO YOU SMOKE CIGARETTES? IF FORMER SMOKER, WHEN DID YOU QUIT? _____

IF YES, HOW MANY PACKS PER DAY? _____

2 ☐ YES ☐ NO DO YOU DRINK ALCOHOLIC BEVERAGES NOW OR DID YOU BEFORE YOU BECAME PREGNANT?

IF YES, PLEASE INDICATE NUMBER OF DRINKS PER WEEK: _____

WHAT TYPE OF DRINKS? _____

3 PLEASE LIST ANY MEDICATIONS TAKEN SINCE YOUR LAST PERIOD, INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER DRUGS, MULTIVITAMINS, OTHER SUPPLEMENTS, AND ANY HERBAL MEDICINES: _____

_____

4. ☐ YES ☐ NO HAVE YOU USED ANY STREET DRUGS SINCE YOUR LAST MENSTRUAL PERIOD (EG. COCAINE, MARIJUANA)?

IF YES, PLEASE INDICATE NUMBER OF USES PER WEEK: _____

WHAT TYPE OF DRUGS? _____

5 ☐ YES ☐ NO DO YOU HAVE ANY REASON TO BELIEVE YOU MAY HAVE BEEN EXPOSED TO HIV/AIDS (EG, A HISTORY OF BLOOD TRANSFUSION, INTRAVENOUS DRUG USE, MULTIPLE SEXUAL PARTNERS, SEXUAL EXPOSURE TO A GAY OR BISEXUAL MALE, OR SEXUAL EXPOSURE TO AN INTRAVENOUS DRUG USER)?

6. ☐ YES ☐ NO HAVE YOU BEEN EXPOSED TO CHEMICALS (EG. PESTICIDES, LEAD, HAZARDOUS MATERIALS/AGENTS) OR RADIATION (EG. X-RAYS) SINCE YOU BECAME PREGNANT?

IF YES, PLEASE DESCRIBE _____

7. ☐ YES ☐ NO ARE YOU ON A RESTRICTED DIET?

IF YES, PLEASE DESCRIBE _____

GYNECOLOGIC HEALTH HISTORY

1 WHEN WAS YOUR LAST PAP TEST? _____

☐ YES ☐ NO HAVE YOU RECEIVED THE HPV VACCINE?

☐ YES ☐ NO HAVE YOU EVER HAD AN ABNORMAL PAP TEST?

IF YES, WHEN AND HOW WERE YOU TREATED? _____

_____

WHAT WAS THE DIAGNOSIS? _____

☐ YES ☐ NO HAVE YOU EVER HAD HPV?

2 ☐ YES ☐ NO HAVE YOU EVER HAD ☐ GONORRHEA ☐ CHLAMYDIA ☐ PELVIC INFLAMMATORY DISEASE

IF YES, WHEN, HOW, AND WHERE WERE YOU TREATED? _____

3 ☐ YES ☐ NO HAVE YOU EVER HAD HERPES?

IF YES, HOW OFTEN DO YOU HAVE OUTBREAKS? _____

☐ YES ☐ NO HAVE YOU EVER HAD SYPHILIS?

IF YES, HOW, WHEN, AND WHERE WERE YOU TREATED? _____

4. ☐ YES ☐ NO HAVE YOU EVER USED AN IUD (INTRAUTERINE DEVICE) FOR CONTRACEPTION?

IF YES, PLEASE INDICATE WHEN: _____

☐ YES ☐ NO DID YOU HAVE ANY PROBLEM WITH THE IUD?

IF YES, PLEASE DESCRIBE: _____

5. ☐ YES ☐ NO HAVE YOU BEEN TREATED FOR INFERTILITY?

IF YES, PLEASE DESCRIBE WHEN AND TREATMENT RECEIVED: _____

_____

6 ☐ YES ☐ NO DO YOU HAVE ANY OTHER CONCERNS RELATED TO YOUR PAST HEALTH HISTORY?

IF YES, PLEASE LIST: _____

_____

FAMILY HISTORY & GENETIC SCREENING

1 WHAT IS YOUR ETHNICITY? _____ WHAT IS THE ETHNICITY OF THE BABY'S FATHER? _____

2. ☐ YES ☐ NO HAVE YOU OR HAS THE BABY'S FATHER HAD A CHILD BORN WITH A BIRTH DEFECT?

IF YES, PLEASE DESCRIBE: _____

3. ☐ YES ☐ NO DID EITHER YOU OR THE BABY'S FATHER HAVE A BIRTH DEFECT?

IF YES, PLEASE DESCRIBE: _____

4. PLEASE DESCRIBE ANY SPECIAL NEEDS THAT HAVE OCCURRED IN CHILDREN OF YOUR FAMILY OR THE BABY'S FATHER'S FAMILY (EG, MENTAL RETARDATION, BIRTH DEFECTS, EARLY INFANT DEATH, DEFORMITIES, OR INHERITED DISEASES, SUCH AS HEMOPHILIA, MUSCULAR DYSTROPHY, OR CYSTIC FIBROSIS):

_____

_____

_____

HOW IS THIS CHILD/PERSON RELATED TO YOU? _____

5 ☐ YES ☐ NO DO YOU OR DOES THE BABY'S FATHER HAVE A HISTORY OF PREGNANCY LOSSES (MISCARRIAGES OR STILLBIRTHS)?

IF YES, HAVE EITHER OF YOU HAD GENETIC COUNSELING? ☐ YES ☐ NO

IF YES, HAVE EITHER OF YOU HAD CHROMOSOMAL TESTING? ☐ YES ☐ NO

WHERE AND WHAT WERE THE RESULTS? _____

6 SOME GENETIC PROBLEMS OCCUR MORE IN COUPLES WITH CERTAIN RACIAL OR ANCESTRAL BACKGROUNDS. PLEASE CHECK IF YOU ARE, OR THE BABY'S FATHER IS, OF ONE OF THESE BACKGROUNDS

☐ YES ☐ NO EASTERN EUROPEAN JEWISH (ASHKENAZI) ANCESTRY

IF YES, HAVE YOU HAD TAY-SACHS SCREENING TESTS? ☐ YES ☐ NO

IF YES, HAVE YOU HAD A CANAVAN SCREENING TEST? ☐ YES ☐ NO

IF YES, HAVE YOU HAD CYSTIC FIBROSIS SCREENING? ☐ YES ☐ NO

IF YES, HAVE YOU HAD FAMILIAL DYSAUTONOMIA SCREENING? ☐ YES ☐ NO

DATE _____ RESULT: _____

☐ YES ☐ NO AFRICAN AMERICAN

IF YES, HAVE YOU HAD SICKLE CELL SCREENING? ☐ YES ☐ NO

DATE: _____ RESULT: _____

☐ YES ☐ NO MEDITERRANEAN ANCESTRY OR SOUTHEAST ASIAN ANCESTRY

IF YES, HAVE YOU HAD SCREENING FOR INHERITED FORMS OF ANEMIA SUCH AS THALASSEMIA? ☐ YES ☐ NO

☐ YES ☐ NO FRENCH CANADIAN OR CAJUN ANCESTRY

IF YES, HAVE YOU HAD TAY-SACHS SCREENING TESTS? ☐ YES ☐ NO

7. ☐ YES ☐ NO HAVE YOU HAD CYSTIC FIBROSIS SCREENING?

8. PLEASE LIST ANY OTHER CONCERNS YOU HAVE ABOUT BIRTH DEFECTS OR INHERITED DISORDERS

_____

_____

_____

_____

_____

_____

_____

9 ☐ YES ☐ NO DO YOU WANT TO HAVE A DOWN SYNDROME RISK ASSESSMENT?

10. ☐ YES ☐ NO IS THE FATHER 50 YEARS OR OLDER?

PSYCHOSOCIAL SCREENING*	
1. ☐ YES ☐ NO	DO YOU HAVE ANY PROBLEMS (JOB, TRANSPORTATION, ETC.) THAT PREVENT YOU FROM KEEPING YOUR HEALTH CARE APPOINTMENTS?
2. ☐ YES ☐ NO	DO YOU FEEL UNSAFE WHERE YOU LIVE?
3. ☐ YES ☐ NO	ARE YOU EXPOSED TO SECOND-HAND SMOKE? ☐ YES ☐ NO IN THE PAST 2 MONTHS, HAVE YOU USED ANY FORM OF TOBACCO?
4. ☐ YES ☐ NO	IN THE PAST 2 MONTHS, HAVE YOU USED DRUGS OR ALCOHOL (INCLUDING BEER, WINE, OR MIXED DRINKS)?
5. ☐ YES ☐ NO	IN THE PAST YEAR, HAVE YOU BEEN THREATENED, HIT, SLAPPED, OR KICKED BY ANYONE YOU KNOW?
6. ☐ YES ☐ NO	HAS ANYONE FORCED YOU TO PERFORM ANY SEXUAL ACT THAT YOU DID NOT WANT TO DO?
7. ON A 1-5 SCALE, HOW DO YOU RATE YOUR CURRENT STRESS LEVEL?	LOW 1 2 3 4 5 HIGH
8. HOW MANY TIMES HAVE YOU MOVED IN THE PAST 12 MONTHS? _____	
9. IF YOU COULD CHANGE THE TIMING OF THIS PREGNANCY, WOULD YOU WANT IT ☐ EARLIER ☐ LATER ☐ NOT AT ALL	

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____

PATIENT SIGNATURE

_____

PRINT NAME

_____

DATE

Notes

PATIENT NAME	BIRTH DATE: / /	ID NO:	DATE: / /

GENETIC SCREENING*/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80			12. HUNTINGTON CHOREA		
2. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. MENTAL RETARDATION/AUTISM		
3. CONGENITAL HEART DEFECT			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. DOWN SYNDROME			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
6. CANAVAN DISEASE (ASHKENAZI JEWISH)			16. BIRTH DEFECTS NOT LISTED ABOVE		
7. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)			17. RECURRENT PREGNANCY LOSS OR A STILLBIRTH		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN AMERICAN)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. MUSCULAR DYSTROPHY			19. ANY OTHER		
11. CYSTIC FIBROSIS					

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

INFECTION HISTORY	YES	NO	
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5. HISTORY OF STIs: GONORRHEA ☐ CHLAMYDIA ☐ HPV ☐ SYPHILIS ☐ PID ☐
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			6. HIV INFECTION YES ☐ NO ☐
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			7. HISTORY OF HEPATITIS
4. PRIOR GBS-INFECTED CHILD			8. OTHER (SEE COMMENTS)

COMMENTS: _____

INTERVIEWER'S SIGNATURE: _____

IMMUNIZATIONS	YES (MONTH/YEAR) ___/___	NO	IF NO, POSTPARTUM VACCINE INDICATED?	IMMUNIZATIONS	YES (MONTH/YEAR) ___/___	NO	IF NO, POSTPARTUM VACCINE INDICATED?
TDAP or TD				HEPATITIS A (WHEN INDICATED)			
INFLUENZA†				HEPATITIS B (WHEN INDICATED)			
VARICELLA†				MENINGOCOCCAL (WHEN INDICATED)			
MMR†				PNEUMOCOCCAL (WHEN INDICATED)			

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the MMR and varicella vaccines postpartum if needed.

INITIAL PHYSICAL EXAMINATION

DATE: ___/___/___ WEIGHT: _____ HEIGHT _____ BMI: _____ BP: _____

1. MEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. TEETH	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. SYMPTOMS SINCE LMP	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	_____ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	_____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals): _____

EXAM BY: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Your surgeon is requesting the services of a Registered Nurse First Assist (RNFA). This is common practice for surgical procedures where an extra pair of skilled hands is necessary to assist the surgeon during your operation. This RNFA is in independent practice and is not employed by your surgeon or hospital. She will file a claim with your insurance company for her services, which are separate from your surgeon and the hospital.

If you have Medicare or Tricare

Currently, Medicare, Tricare and Care Improvement Plus do not recognize Certified Registered Nurse First Assists and will deny payment of these services as "Not Customary". If this is your insurance, you will be billed directly. This financial obligation will be 20 percent of the surgeon's allowable rate.

If you have Insurance coverage other than, or in addition to, Medicare or Tricare

Your insurance will be billed for the services of the CRNFA. If your insurance denies payment, an appeals process will be submitted. If the appeals process continues to deny reimbursement, you will receive a bill and will be responsible for the payment of these services. Your responsibility will be limited to 20 percent of the surgeon's allowable charges.

I agree to be responsible for the payment for services provided by my surgeon's designated Registered Nurse First Assist.

_____	Elena Wilson, RNFA
Surgeon's Name	Surgical Assistant
_____	_____
Patient's Name	Date of Surgery
_____	_____
Signature of Patient	Date Signed

Current Pharmacy: Name: _____ Location: _____ Phone: _____

Preferred Lab: Name: _____ Location: _____ Phone: _____

Date of last Pap Smear? _____ ☐ Normal ☐ Abnormal

If pap was abnormal, were any of the following performed: ☐ Colposcopy ☐ Cryosurgery ☐ LEEP/Laser/Conization

Date of last Mammogram? _____ ☐ Normal ☐ Abnormal ☐ Never had a Mammogram

Date of last Bone Density? _____ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had a Bone Den

Date of last Colonoscopy? _____ ☐ Never had a Colonoscopy

Family History:

Father's side: (including siblings, uncles/aunts, and grandparents)

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other _____

Mother's side: (including siblings, uncles/aunts, and grandparents)

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other _____

Social History:

Exercise	☐ Yes	☐ No	Type(s) and frequency _____					
Alcohol use	☐ Yes	☐ No	If yes, _____ drink(s) per day/week/month					
Tobacco use	☐ Yes	☐ No	If yes, _____ pack(s) per day for _____ year(s)					
Caffeine	☐ Yes	☐ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week/mo					
Recreational Drug use	☐ Yes	☐ No	Type(s) and frequency _____					
Emotional Abuse	☐ Yes	☐ No	If yes, are you safe now	☐ Yes	☐ No	Counseling	☐ Yes	☐ No
Physical Abuse	☐ Yes	☐ No	If yes, are you safe now	☐ Yes	☐ No	Counseling	☐ Yes	☐ No
Sexual Abuse	☐ Yes	☐ No	If yes, are you safe now	☐ Yes	☐ No	Counseling	☐ Yes	☐ No

Review of Systems - Do you have any of the following symptoms TODAY?

GENERAL:

☐ Yes ☐ No Hemorrhoids
☐ Yes ☐ No Recent weight gain/loss of 25 lbs.
☐ Yes ☐ No Fever
☐ Yes ☐ No Vision problems (excluding glasses)
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Chronic Cough
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Blood in stools
☐ Yes ☐ No Heartburn/reflux

GYNECOLOGY:

☐ Yes ☐ No Abnormal Frequent urination
☐ Yes ☐ No Burning w/ urination
☐ Yes ☐ No Incontinence
☐ Yes ☐ No Abnormal Urinary Urgency
☐ Yes ☐ No Bladder infection
☐ Yes ☐ No Abdominal pain
☐ Yes ☐ No Abnormal vaginal discharge
☐ Yes ☐ No Irregular vaginal bleeding
☐ Yes ☐ No Pelvic pain
☐ Yes ☐ No Painful intercourse
☐ Yes ☐ No Breast lumps
☐ Yes ☐ No Breast pain
☐ yes ☐ No Back pain
☐ Yes ☐ No Depression/anxiety

(**PLEASE NOTE**: Extra charges may/will occur if both a Well Woman exam and Problem visit are discussed on the same da

_____ _____
Patient Signature Date

_____ _____
Clinician Signature Date

NAPLES WOMEN'S CENTER: NEW PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Age: _____ Today's Date:_____

How did you hear about our office? Please circle: Friend/Family Online Primary Doctor Other _____

Reason for your visit today: Well Woman Exam or Problem visit: _____

WOULD YOU ACCEPT A BLOOD TRANSFUSION IN A LIFE OR DEATH SITUATION? (required): ☐ Yes ☐ No

Medical History: Have you had any of the following?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Bladder Infections
- ☐ Blood Clots in Lungs/Legs
- ☐ Blood Transfusion
- ☐ Cancer _____
- ☐ Chickenpox
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy/ Seizures
- ☐ Gall Bladder Disease
- ☐ Heart Disease/ Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease/Stones
- ☐ Liver Disease/Hepatitis ___
- ☐ Migraines
- ☐ Pelvic Infections
- ☐ Reflux/Heartburn/Ulc
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other: _____

List ALL medications you are currently taking, including over-the-counter medications, vitamins, and herbal remedie

_____ _____ _____ _____

_____ _____ _____ _____

List any allergies to medications: _____ ☐ No Known Allergi

Surgical History - List all surgeries with dates:

_____ _____

_____ _____

Obstetrical History

☐ Check here if you have **NEVER** been pregnant.

Number of pregnancies ____ **Number of elective abortions** _____ **Number of ectopic pregnancies** _____

Number of living children _____ **Number of miscarriages** _____ **Number of stillbirths** _____

Gyn History:

Age of first period _____ If in Menopause, what age/year _____ HPV/Gardasil Vaccine: ☐ Yes ☐ No

Date of last period _____

Cycle Length: every _____ days
lasting _____ days

Periods are: ☐ Regular ☐ Irregular ☐ Painful

Flow is: ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Are you sexually active ☐ Yes ☐ No ☐ Never **Lifetime Partners:** ☐ Less than 5 ☐ More than 5

Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other _____

Method of Birth Cont

- ☐ Condoms
- ☐ Natural Family Planning
- ☐ Pills: _____
- ☐ Vasectomy (Partner)
- ☐ Depo Provera
- ☐ IUD: Brand _____ Year inserted ____
- ☐ Tubal/ Essure
- ☐ Vaginal Ring
- ☐ Cervical Cap
- ☐ Sponge
- ☐ Spermicide
- ☐ Withdrawal
- ☐ Hysterectomy
- ☐ None

Have you ever had any of the following STDs?

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ HIV
- ☐ HPV
- ☐ Syphilis
- ☐ Trichomonas
- ☐ None

NAPLES WOMEN'S CENTER

Health

I have been furnished information in the form of a Brochure prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), pursuant to the Section 766.316, Florida Statues, by Naples Women's Center and have been advised that all physicians in the Physicians group are participating physician (s) in that program, wherein certain limited compensation is available in the event certain types of qualifying neurological injuries, may occur during labor, delivery or resuscitation in a hospital.

For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, Post Office Box 14567, Tallahassee, Florida 32317-4567. (800) 398-2129.

I specifically acknowledge that I have received a copy of the Brochure prepared by NICA.

DATED this _____ day of _____,20_____,

_____
Signature of Patient

_____
Printed Name of Patient
Social Security No.: _____

Attest:

_____
Nurse or Physician

Date: _____

Note: This Suggested Form is to be utilized only upon the advice of the Physician's Group's counsel. This form is not a required NICA form.