MAETOZO TOTAL WOMAN'S CARE OF ST. AUGUSTINE, LLC

1301 PLANTATION ISLAND DR. STE 103
ST. AUGUSTINE, FL 32080
PH: 904.461.5330
FAX: 904.461.5334

Patient Demographics

Patient Name	Home Phone
Home Address	Work Phone
City State ZIP	Cell Phone
Date of Birth Age	Email Address
Occupation	Social Security Number
Employer	Marital Status
Work Address	City State ZIP
Referred By	Primary Language Spoken

Spouse/Emergency Contact

Name	Date of Birth
Relationship to Patient	Phone Number

Insurance Information

Primary Insurance Name	Insurance Phone Number
Member/Subscriber ID	Group Number
Name of Subscriber	Subscriber's Date of Birth
Relationship to Patient	Work Phone Number

Release of Information

I authorize the release of any medical information necessary to process a claim.	
Signed by Subscriber	Date

Assignment of Benefits

I authorize payment of medical benefits to myself or the name provider for professional services rendered.	
Signed by Subscriber	Date

Pharmacy Information

Name of Pharmacy	Pharmacy Phone Number
Pharmacy Address	

GYN HISTORY

Do you have any current problems?

☐ Yes
☐ No

If yes, please explain

Please answer all of the following, as appropriate.

When was your last wellness exam?

Please enter date

Click or tap to enter a date.

When was your last Pap Smear?

Click or tap to enter a date.

Have you ever had an abnormal Pap Smear?

☐ Yes
☐ No

If yes, when?

Click or tap to enter a date.

How was it treated?

☐ No Treatment
☐ Freezing
☐ Surgery
☐ 6-month follow up pap smear
☐ I did not follow up

Have you ever had a Mammogram?

☐ Yes
☐ No

If yes, when was your last mammogram?

Click or tap to enter a date.

What were the results?

☐ Normal
☐ Abnormal

Have you ever had a Pelvic Ultrasound?

☐ Yes
☐ No

If yes, when was your last pelvic ultrasound?

Click or tap to enter a date.

What were the results?

☐ Normal
☐ Abnormal

Any Ovarian Problems?

☐ Yes
☐ No

Please Specify

Have you had an Endometrial Biopsy?

☐ Yes
☐ No

If yes, when?

Click or tap to enter a date.

History of Fibroids?

☐ Yes
☐ No

History of Uterine Polyps?

☐ Yes
☐ No

History of Endometriosis?

☐ Yes
☐ No

History of PCOS?

☐ Yes
☐ No

Have you had BRCA testing?

☐ Yes
☐ No

If yes, when?

Click or tap to enter a date.

Have you had a thyroid ultrasound?

☐ Yes
☐ No

If yes, when?

Click or tap to enter a date.

Have you ever had a Bone Density?

☐ Yes
☐ No

If yes, when was your last bone density?

Click or tap to enter a date.

What were the results?

☐ Normal
☐ Osteopenia
☐ Osteoporosis

Have you ever had a Colonoscopy?

☐ Yes
☐ No

If yes, when was your last colonoscopy?

Click or tap to enter a date.

What were the results?

☐ Normal
☐ Abnormal

MENOPAUSE (complete only if applicable; skip, if otherwise)

Age of first period

Age of last period

Hormone use

☐ Past
☐ Present
☐ Never

Please Specify

Any vaginal bleeding within the past 12 months?

☐ Yes
☐ No

MENSTRUATION (complete only if applicable; skip, if otherwise)

Age of first period

First day of last NORMAL period

Click or tap to enter a date.

Do you menstruate regularly?

☐ Yes
☐ No

How many days from the start of one period to the start of the next period?

☐ Irregular
☐ > 45 days apart

☐ 33 - 45 days apart
☐ 21 - 32 days apart
☐ < 21 days apart
☐ I don't know

How many days of bleeding do you have with your typical period?

☐ > 7 days
☐ 2 – 7 days
☐ 1 day

How many pads/tampons do you use per day?

☐ 1-3
☐ 4-6
☐ 7+

Spotting between periods?

☐ Yes
☐ No

Painful periods?

☐ Yes
☐ No

Heavy periods?

☐ Yes
☐ No

CONTRACEPTIVE(S)

Birth control use?

☐ Yes
☐ No

Type

☐ Condoms
☐ Essure
☐ Interauterine device (IUD)
☐ Nexplanon
☐ Family Planning
☐ Oral Contraceptive Pill
☐ Patch
☐ Ring
☐ Shot
☐ Tubes tied or removed
☐ Vasectomy
☐ Other

SEXUAL HISTORY

Are you currently in a sexual relationship?

☐ Yes
☐ No

Number of sexual partners in the past year

Sexual Partner(s)

☐ With men
☐ With Women
☐ With both men and women

Intimate partner violence

☐ Yes
☐ No

Changed sexual partners since last well-woman exam

☐ Yes
☐ No

History of Transmitted Diseases (STDs)

☐ Yes
☐ No

Please Specify

Have you had the Gardasil Vaccine

☐ Yes
☐ No

If yes, when was your last injection?

Click or tap to enter a date.

OB HISTORY

Have you had pregnancies in the past?

☐ Yes
☐ No

Total pregnancies

Living pregnancies

Ectoptic pregnancies

Termination

Miscarriage

Premature pregnancies

Type of delivery

☐ Vaginal
☐ Cesarean

Any complications, explain below

DRUGS

Have you used drugs other than those for medical reasons in the past 12 months?

☐ Yes
☐ No

Methamphetamine?

☐ Yes
☐ No

Crack?

☐ Yes
☐ No

LSD?

☐ Yes
☐ No

Ecstasy?

☐ Yes
☐ No

Prescription opiates?

☐ Yes
☐ No

Marijuana?

☐ Yes
☐ No

Ketamine?

☐ Yes
☐ No

PCP?

☐ Yes
☐ No

Cocaine?

☐ Yes
☐ No

Heroin?

☐ Yes

☐ No

If Yes…

Is there a minor (18 years or younger) at risk at home?

☐ Yes
☐ No

Are you still using?

☐ Yes
☐ No

Have you ever injected drugs?

☐ Yes
☐ No

Are you in a treatment program?

☐ Yes
☐ No

How many months ago did you last use?

Choose an item.
☐ 6 – 12 months
☐ 12 – 24 months
☐ > more than 24 months

Health History

Have you ever been diagnosed with the following? (check all that apply)

☐ breast cyst
Click or tap to enter a date.
☐ breast cancer
Click or tap to enter a date.
☐ cervical cancer
Click or tap to enter a date.
☐ colon cancer
Click or tap to enter a date.
☐ ovarian cancer
Click or tap to enter a date.
☐ uterine cancer
Click or tap to enter a date.
☐ depression
Click or tap to enter a date.
☐ diabetes
Click or tap to enter a date.
☐ endometriosis
Click or tap to enter a date.
☐ hyperthyroidism
Click or tap to enter a date.
☐ hypothyroidism
Click or tap to enter a date.
☐ hypertension
Click or tap to enter a date.

☐ incontinence
Click or tap to enter a date.
☐ infertility
Click or tap to enter a date.
☐ osteoarthritis
Click or tap to enter a date.
☐ osteopenia
Click or tap to enter a date.
☐ osteoporosis
Click or tap to enter a date.
☐ pelvic inflammatory disease
Click or tap to enter a date.
☐ rectal prolapse
Click or tap to enter a date.
☐ uterine prolapse
Click or tap to enter a date.
☐ bladder prolapse
Click or tap to enter a date.
☐ uterine fibroids
Click or tap to enter a date.
☐ Other

Please Specify:

Have you ever had surgery?

☐ Yes
☐ No

How many?

Have you recently had any important laboratory or diagnostic tests such as CT scan, ultrasound, blood tests, etc?

☐ Yes
☐ No

Date:

Click or tap to enter a date.

Please Specify:

Are you taking any prescribed medications?

☐ Yes
☐ No

Please list the name and dosage of prescribed medications:

Are you taking any over the counter medications?

☐ Yes
☐ No

Please list the name and dosage of OTC medications, along with any herbal products:

Do you have allergies to medications?

☐ Yes
☐ No

Please list the name(s) of the medication(s):

Do you have food allergies?

☐ Yes
☐ No

Please specify:

Do you have seasonal allergies?

☐ Yes
☐ No

Please specify:

Are you allergic to latex?

☐ Yes
☐ No

Does anyone in your family have the following?

☐ Alzheimer's Disease
☐ Birth Defects
☐ Blood clot in leg or lung

☐ Breast Cancer
☐Colon Cancer
☐ Drug or Alcohol Addiction
☐ Diabetes
☐ Heart Disease
☐ Hepatitis
☐ HIV
☐ High Cholesterol
☐ High Blood Pressure
☐ Inherited Disease such as Cystic Fibrosis, Hemophilia, Fragile X, Etc.
☐ Mental Illness
☐ Osteoporosis
☐ Ovarian Cancer
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Uterine Cancer

Please select relatives with high cholesterol:

☐ Mother
☐ Father
☐ Brother
☐ Sister
☐ Son
☐ Daughter
☐ Paternal Grandfather
☐ Paternal Grandmother
☐ Maternal Grandfather
☐ Maternal Grandmother
☐ Paternal Uncle
☐ Paternal Aunt
☐ Paternal Cousin
☐ Maternal Uncle
☐ Maternal Aunt
☐ Maternal Cousin