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

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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

/ /

When was your last Pap Smear?

/ /

Have you ever had an abnormal Pap Smear?

☐ Yes
☐ No

If yes, when?

/ /

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?

/ /

What were the results?

☐ Normal
☐ Abnormal

Have you ever had a Pelvic Ultrasound?

☐ Yes
☐ No

If yes, when was your last pelvic ultrasound?

/ /

What were the results?

☐ Normal
☐ Abnormal

Any Ovarian Problems?

☐ Yes
☐ No

Please Specify

Have you had an Endometrial Biopsy?

☐ Yes
☐ No

If yes, when?

/ /

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?

/ /

Have you had a thyroid ultrasound?

☐ Yes
☐ No

If yes, when?

/ /

Have you ever had a Bone Density?

☐ Yes
☐ No

If yes, when was your last bone density?

/ /

What were the results?

☐ Normal
☐ Osteopenia
☐ Osteoporosis

Have you ever had a Colonoscopy?

☐ Yes
☐ No

If yes, when was your last colonoscopy?

/ /

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

/ /

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?

/ /

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

Health History

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

☐ breast cyst ☐ breast cancer ☐ cervical cancer ☐ colon cancer ☐ ovarian cancer ☐ uterine cancer

☐ depression ☐ diabetes ☐ endometriosis ☐ hyperthyroidism ☐ hypothyroidism ☐ hypertension

☐ incontinence ☐ infertility ☐ osteoarthritis ☐ osteopenia ☐ osteoporosis ☐ pelvic inflammatory disease

☐ rectal prolapse ☐ uterine prolapse ☐ bladder prolapse ☐ uterine fibroids ☐ Other

Please Specify:

Have you ever had surgery?

☐ Yes

☐ No

How many?

What type?

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

☐ Yes

☐ No

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?

Father

☐ Alzheimer's Disease ☐ Birth Defects ☐ Blood clot in ☐ 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

Mother

☐ Alzheimer's Disease ☐ Birth Defects ☐ Blood clot in ☐ 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

Siblings

☐ Alzheimer's Disease ☐ Birth Defects ☐ Blood clot in ☐ 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

Maternal Grandfather

☐ Alzheimer's Disease ☐ Birth Defects ☐ Blood clot in ☐ 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

Maternal Grandmother

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Maternal Uncle

☐ Alzheimer's Disease ☐ Birth Defects ☐ Blood clot in ☐ 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

Maternal Aunt

☐ Alzheimer's Disease ☐ Birth Defects ☐ Blood clot in ☐ 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

Paternal Grandfather

☐ Alzheimer's Disease ☐ Birth Defects ☐ Blood clot in ☐ 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

Paternal Grandmother

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