Patient Information Chart # ________________

Name ____ Date of Birth __________________ Age __________
Address ____
City ____ State ________________ Zip _______________
Social Security # _____________________________ Marital Status __________________Ethnicity ________________
Phone ____ Can we leave a message? ______Yes ______ No
Highest level of education completed ________________________

Emergency Contact

Name____Relationship ____________ Phone _______________________

Pregnancy History

First day of last menstrual period ____________________________________ (month/date/year)

______ Total number of previous pregnancies ______ Total Live Births ______ Total C-sections
______ Total Miscarriages ______ Total Abortions
____ Ages of living children, if applicable
Did you have any complications during or after your pregnancies? ______ Yes ______ No
If yes, please explain ____
Are you currently breast-feeding? ______ Yes ______ No

Birth Control Information

Were you using a birth control method when you became pregnant? ______ Yes ______ No
If yes, what type? ____
Have you ever used any of the following birth control methods? Check all that apply

______ Birth control pills ______ Depo-Provera ______IUD ______ Patch
______Nexplanon ______NuvaRing ______Condom ______ Other

Did you have any problems with the method(s) used? ______ Yes ______ No
If yes, please explain ____

Are you interested in being prescribed birth control today? ______ Yes ______ No

I declare that to the best of my knowledge and belief that the above information provided is true and correct.
I have read and agreed to the privacy notice of Bristol Women's Health. A copy will be provided upon my request.

____ _______________________
Patient Signature Date

____ _______________________
Parent/Legal Guardian/Interpreter Signature Date

Bristol Women's Health
Medical History

Chart # ____________________

Patient Name: ________________________________ DOB: ____________________

Please list the pertinent information below. If none, write "none"

Allergies ____

____

Medications (prescription and over-the-counter)______________________________

____

Surgical History ____

____

Medical History ____

____

Do you smoke cigarettes/vape? _______ Yes _______ No If yes, how much? _______/day

Do you drink alcohol? _______ Yes _______ No If yes, how much? ________________

Are you or have you ever been addicted to any substance(s)? _______ Yes _______ No

If yes, what substance(s) and when? ____

Are you currently taking any of the following medications?

- Darunavir (Prescobix, Prezita) _______ Yes _______ No
- Kaletra _______ Yes _______ No
- Reyataz _______ Yes _______ No
- Suboxone (Subutex, Zubsolv, Buprenorphine) _______ Yes _______ No
- Naloxone _______ Yes _______ No
- Posaconazole (Noxafil) _______ Yes _______ No
- Plavix _______ Yes _______ No
- Naltrexone _______ Yes _______ No
- Steroids _______ Yes _______ No

Do you now or have you ever had any of the following? (Please check all that apply)

_______Uterine Fibroid Tumor _______ Infection of Ovaries/Tubes _______ Cancer

_______ Hepatitis _______ Heart Disease _______ Diabetes

_______ Liver Disease _______ Thyroid Disease _______ Sickle Cell Anemia

_______ Blood Clotting Disorder _______ Anemia _______LEEP Procedure

_______ Abnormal Pap Smear _______ Sexually Transmitted Disease

____ ____________________

Patient Signature Date

____ ____________________

Parent/Legal Guardian/Interpreter Signature Date

Privacy Notice

Bristol Women's Health

Right to Access Records

Patients have the rights to see and receive copies of their records after signing a record release form. The patient has a right to see anything in the record. Copies of the chart may be made for a small fee.

Right to Request Restriction

Patients have the right to request restrictions on who sees their records. Any request that is unreasonable will be dealt with on an individual basis.

Right to Confidential Communication

Patients have the right to receive communications about their record in a confidential manner. Communications will be made through telephone calls unless otherwise requested by the patient and documented in their record.

Right to Amend the Record

Patients have a right to amend their records when they disagree with the content, but physicians have the right to deny these requests. A record cannot be changed but a line may be drawn through the disrupted entry. The physician may then write an addendum.

Right to an Accounting of Disclosures

Patients have the right to know everyone to whom the office discloses record information for purposes other than treatment, payment, and healthcare operation.

A log, as required by HIPAA, will be kept showing each disclosure and the person to whom it is made. This will also show what information is provided and the purpose. This office will only document the reasons for which the patient's authorization is required.

Disclosure of Information with Extenuating Circumstances

Health information may be given to an authorized contact in case of an emergency or other circumstances with proper authorization and documentation.

Health information may be given to other physicians under emergency conditions.

Information may be given to the proper authorities when neglect or abuse is alleged or suspected.

Information may be provided to the courts or other agencies when a subpoena is issued to this office.

By signing my name below, I agree that I have read and understood the above information.

______________________________ ______________________________

Patient Signature | Date

______________________________ ______________________________

Parent/Legal Guardian/Translator Signature | Chart #

Patient Rights and Responsibilities

Bristol Women's Health

1. I will receive professional, courteous, and considerate treatment from my provider and his/her staff with recognition of my dignity and need for privacy.
2. I will participate in the decision regarding my healthcare. This includes the right to accept or refuse medical treatment.
3. I have access to a phone number which I can use to receive instructions from a provider 24 hours a day. 365 days a year.
4. I will voice my grievances concerning treatment by the provider and/or his/her staff.
5. I will provide to the extent possible the information needed by the provider in order to care for me (includes medication conditions, medications, present complaints, past illnesses, hospitalizations, and all other matters relevant to care). In addition, any illnesses which could be a potential hazard to the provider or staff should be reported so that appropriate measures may be taken to protect the provider and staff from infection.
6. I will follow instructions and guidelines given by the provider and/or staff.
7. I will show consideration and respect to the provider and staff.
8. I will make the required payment (if applicable).
9. I understand that recording either voice or video without the consent of the provider or staff is not permissible in this facility. I understand that I may speak with the provider or staff about recording for instructional purposes prior to doing so.

______________________________________ ______________________________

Patient Signature Date

______________________________________ ______________________________

Witness Signature Chart #