

Memphis Center for Reproductive Health

PATIENT DEMOGRAPHIC

ALL INFORMATION IS CONFIDENTIAL. PLEASE PRINT IN BLACK INK

PT# _____
DATE: _____
DOB: _____

Legal Name: _____ Age: _____

Preferred Prefix: _____ / Preferred Name: _____ Preferred Pronoun: _____

Address: _____
Full Address City County State Zip

Patient Phone Number: (H): _____ (C): _____

MCRH can leave a message at: (circle) Home Cell With a person (name): _____

Email address _____ Can we add you to our mailing list

Do you have a Primary Medical Provider? Yes / No Name: _____ Phone # (____) _____

Occupation: _____ Social Security #: _____

Do you have health insurance? YES NO Type _____

Emergency Contact Person: _____ Relationship to you: _____ Phone # (____) _____

Does this person know that you are here for services? YES NO

Who is with you today? _____ Phone #: (____) _____

Have you been a patient at MCRH in the past (circle) YES NO Year of visit: _____

Has your medical history changed since your last visit? YES NO

If yes, please explain: _____

Please circle: Married Partnered Single Divorced Widowed

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

Gender: (Please Circle) Male Female Transgender: F to M M to F Other: _____

Ethnicity: (Please circle any/all that apply)

Asian African American Caucasian Hispanic American Indian Other: _____

How did you hear about us? (Please circle all that apply)

- 1. I was a previous patient
- 2. White Pages
- 3. Yellow Pages
- 4. Family / Friend
- 5. MD / Medical Facility
- 6. MCRH Postcard
- 7. Internet
 - a. MCRH Website
 - b. Google / Yahoo / etc
 - c. other
- 8. 411 / Info
- 9. Newspaper Ad
- 10. Abortion Hotline / NAF
- 11. Other: _____

According to Chapter 1200-8-13 "Standards for Ambulatory Surgical Treatment Centers" for the State of TN

Any adult or emancipated minor may execute an advance for driective health care

Do you want to execute an advance directive for health care?

____YES ____NO

Signature of patient: _____ Date: _____

(IF YOU ARE HERE FOR AN ABORTION, PLEASE COMPLETE THE BACK OF THIS SHEET)

If you are having an abortion today please answer the following questions

Circle all the words that describe how you feel right now:

Sad Happy Angry Confident Guilty Confused Scared Relieved Numb Ashamed
Resolved Selfish Trapped Irresponsible Peaceful Disappointed Comfortable Grieving

Is anyone pressuring or forcing you to have this abortion? ____ Yes ____ No

I understand my alternatives to having an abortion. I am firm in my decision to terminate this pregnancy.

(Please Initial) ____ Yes ____ No

I understand that it is against the law for anyone, regardless of the person's relationship to me, to coerce me to have an abortion against my will. An abortion cannot be performed on me unless I have freely given voluntary and informed consent. I have the right to contact a local or state law enforcement agency to receive protection from any actual or threatened criminal offense to coerce an abortion.

Patient Signature

Date

DO NOT WRITE BELOW THIS LINE - MCRH STAFF ONLY

PAP smear? ____ Yes ____ No

Prescription for Birth Control ____ Yes ____ No Method _____

Ibuprofen taken? ____ Yes ____ No _____

Patient Educator Signature _____

Date: _____

OTHER PATIENT CONCERNS _____



Memphis Center for Reproductive Health

MEDICAL HISTORY

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PT# _____

DATE: _____

DOB: _____

Legal Name: _____ Age: _____

Preferred Name: _____

Primary Reason for Visit: _____

Past Medical History:

ALLERGIES

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	LATEX
<input type="checkbox"/>	<input type="checkbox"/>	TETRACYCLINE/DOXYCYCLINE
<input type="checkbox"/>	<input type="checkbox"/>	ASPRIN
<input type="checkbox"/>	<input type="checkbox"/>	NOVACAINE/LIDOCAINE
<input type="checkbox"/>	<input type="checkbox"/>	IODINE/SHELLFISH
<input type="checkbox"/>	<input type="checkbox"/>	Do you have allergies to any other drug? If YES, list: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any medications (including vitamins or herbal medications): _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any unprescribed drugs or medications? If YES, list: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently breast feeding?

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? # per day _____ How many years _____
<input type="checkbox"/>	<input type="checkbox"/>	Would you like a referral for smoking cessation?
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? If yes: How often do you drink more than 2 drinks: Daily Weekly Monthly
<input type="checkbox"/>	<input type="checkbox"/>	Do you or your partner use injection medications or drugs?
<input type="checkbox"/>	<input type="checkbox"/>	Are you experiencing any neglect, violence or abuse?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any dietary concerns today? If Yes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you you exercise regularly? _____ X per week Type of exercise: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink caffeine? _____ cups per day
<input type="checkbox"/>	<input type="checkbox"/>	Do you need a referral today? FOR: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have children?
<input type="checkbox"/>	<input type="checkbox"/>	Major surgery or car accident (not childbirth)

GENERAL MEDICAL HISTORY

Have YOU ever had:

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	diabetes (gestational or other)
<input type="checkbox"/>	<input type="checkbox"/>	cancer (type: _____)
<input type="checkbox"/>	<input type="checkbox"/>	thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	sickle cell trait or disease
<input type="checkbox"/>	<input type="checkbox"/>	heart murmur / mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	heart attack, heart problem or chest pain
<input type="checkbox"/>	<input type="checkbox"/>	asthma or breathing problems
<input type="checkbox"/>	<input type="checkbox"/>	blurred or double vision
<input type="checkbox"/>	<input type="checkbox"/>	anemia
<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	numbness in arms or legs
<input type="checkbox"/>	<input type="checkbox"/>	blood clots in arms, legs or lungs
<input type="checkbox"/>	<input type="checkbox"/>	redness, pain or swelling in arms or legs
<input type="checkbox"/>	<input type="checkbox"/>	emotional problems (i.e. depression)
<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	liver problems or hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	kidney or bladder problem
<input type="checkbox"/>	<input type="checkbox"/>	stomach problems
<input type="checkbox"/>	<input type="checkbox"/>	gall bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	seizure disorder or epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	genetic abnormality
<input type="checkbox"/>	<input type="checkbox"/>	MD diagnosed migraine headaches
<input type="checkbox"/>	<input type="checkbox"/>	frequent or severe headaches

LIST ANY SURGERIES

_____	YEAR _____
_____	YEAR _____
_____	YEAR _____

LIST ANY HOSPITALIZATIONS (not childbirth) REASONS

_____	YEAR _____
_____	YEAR _____
_____	YEAR _____

FAMILY HISTORY

Have your PARENTS, BROTHERS, OR SISTERS HAD:

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	cancer (type: _____)
<input type="checkbox"/>	<input type="checkbox"/>	diabetes (insulin or diet controlled)
<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	sickle cell trait or disease
<input type="checkbox"/>	<input type="checkbox"/>	death from a heart attack before age 50
<input type="checkbox"/>	<input type="checkbox"/>	epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING:

- | | | | |
|--------------------------|--------------------------|-------------------------------------|------------|
| YES | NO | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital Warts (HPV) | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes (HSV) | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | Syphilis | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic Inflammatory Disease (PID) | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV / AIDS | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been tested for HIV before | _____ year |
| <input type="checkbox"/> | <input type="checkbox"/> | Partner with infection or symptoms | _____ |

PREGNANCY PREVENTION

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | condoms |
| <input type="checkbox"/> | <input type="checkbox"/> | spermicides |
| <input type="checkbox"/> | <input type="checkbox"/> | vasectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | withdrawal |
| <input type="checkbox"/> | <input type="checkbox"/> | cervical cap |
| <input type="checkbox"/> | <input type="checkbox"/> | diaphragm |
| <input type="checkbox"/> | <input type="checkbox"/> | natural family planning |
| <input type="checkbox"/> | <input type="checkbox"/> | birth control pills (type: _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Depo Provera shots |
| <input type="checkbox"/> | <input type="checkbox"/> | Nuvaring (vaginal ring) |
| <input type="checkbox"/> | <input type="checkbox"/> | Ortho Evra (patch) |
| <input type="checkbox"/> | <input type="checkbox"/> | Norplant / Implanon |
| <input type="checkbox"/> | <input type="checkbox"/> | IUD (Intra-uterine Device) |
| <input type="checkbox"/> | <input type="checkbox"/> | tubal ligation |
| <input type="checkbox"/> | <input type="checkbox"/> | problems with any method? |
| | | If "yes" explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you using a method when you or your partner became pregnant? |
| | | What method? _____ |

Female Patients, Please complete this section:

	Year of Pregnancy	Type of Delivery	Weeks Pregnant	Any pregnancy complications?
How many times have you been pregnant? _____				<input type="checkbox"/> hypertension <input type="checkbox"/> postpartum depression <input type="checkbox"/> postpartum hemorrhage <input type="checkbox"/> other treated/how? _____ _____ CDD Cost for a PAP Smear is \$ 13.00
How many pregnancies did you continue to full term (>37-40 weeks)? _____				
How many pregnancies were premature? _____				
How many abortions have you had? _____				
How many miscarriages have you had? _____				
How many living children do you have? _____				

Menstrual History

- When was the first day of your last period? _____
- | | | |
|--------------------------|--------------------------|-----------------------------|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Was it a normal period? |
| | | If NO, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you Currently Pregnant? |
- How often do your periods occur? Every _____ days
- How long do your periods usually last? _____ days
- How old were you when your periods began? _____ years old
- Post menopausal

- | | | |
|--------------------------|--------------------------|---------------------------------------|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking HRT |
| | | How Long? _____ |
| | | What year was your last menses? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | breast surgery, lump or other problem |
| <input type="checkbox"/> | <input type="checkbox"/> | tumor or fibroid in the uterus |
| <input type="checkbox"/> | <input type="checkbox"/> | abnormalities of the uterus |
| <input type="checkbox"/> | <input type="checkbox"/> | sores/bumps in genital area |
| <input type="checkbox"/> | <input type="checkbox"/> | vaginal itching/discharge/odor |
| <input type="checkbox"/> | <input type="checkbox"/> | pain or bleeding with sex |
| <input type="checkbox"/> | <input type="checkbox"/> | loss of interest in sex |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a pelvic exam before? |

Form completed by: Patient Clinician Parent
 Patient Educator Other

Date of last pap smear _____
 Previous abnormal pap smear _____

Signature of patient: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinician Signature: _____ Date: _____