Amani Women's Center

"Making a difference in women's lives!"

OBGYN offices of:

Bryan Myers, M.D., PC
Melody Harrison, NP-C
Saharra Jewell, APN

Date: ______________________________

Last Name	First Name	Middle Name	Date of Birth
Mailing Address	City	State	ZIP
Home Phone	Cell Phone	Work Phone	Age
Email address	SSN	Marital Status	Employment

Emergency Contact Name	Relationship	Phone Number
Name of Spouse/Significant Other	Phone Number	
Pharmacy Name	City	Phone

Do You have insurance? ______________ Insurance name ______________

Insurance ID number		Insurance Group number	
Subscriber name	SSN#	Date of Birth	
Relationship to subscriber		Phone number	
Mailing Address	City	State	ZIP code

Secondary insurance name: ______________________________

Subscriber name	SSN#	DOB	Relationship to subscriber
Mailing address	City	State	Zip code
Insurance ID number		Insurance Group number	

Responsible party/Phone Number ______________________________

Primary Care Physician/Phone number ______________________________

161 Shirley Drive, Winchester, TN 37398 931-962-0450 (ofc.) 931-962-0470 (fax) **1034 McArthur St Manchester, TN 37355** (931-954-5111, 931-962-0470)
106 Westside Dr. Tullahoma, TN 37388 931-393-4700 (ofc.) 931-962-0470 (fax)

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I, the undersigned, certify and acknowledge the following:

- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which include insurance companies, specialists, and other healthcare providers and institutions.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that diagnostic tests may be recommended, and denial of these tests can result in undiagnosed and untreated health conditions.
- I understand that I am financially responsible for all charges not covered by insurance assignment.
- I assume responsibility for all costs of collections, including financial charges, attorney fees and court costs.
- I have checked and know that my insurance company covers Amani Women's Health as a provider in or out of network.
- I understand that medical treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that all co-pays, deductible amounts, or self-pay services are due at the time of service.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized two working days prior to the original appointment, or a late cancellation fee may be charged.
- I acknowledge I received the Amani Women's Health privacy notice attached to this form.
- I have accurately answered all the questions here and on the medical history form and have read all the above information.
- I understand that it is necessary to bring all forms such as disability and FMLA forms to the office one week prior to the time that they are due. I understand that there is a 20.00 fee for these forms.

____

Signature   Date

____

Printed Name

If a personal representative signature appears above, please describe the authority to do so

____

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Privacy Practices Notice of Acknowledgment

Name:_______________________________________

Acknowledgment

___________I acknowledge that I have been offered the **Notice of Privacy Practices** but declined.

___________I acknowledge that I have been offered the **Notice of Privacy Practices.**

I give my permission to speak to the following on any medical issue:

	Name
_____My spouse	______________________________
_____My child/children	______________________________
_____My caregiver	______________________________
_____Other	______________________________

Check all that apply.

_____I give my permission to leave messages on my answering machine or with anyone answering my personal phone.

_____I give my permission to contact me at my place of employment. If I am unavailable, I give permission for a message to be left to return the call.

_____I give my permission for my physician to fax any information regarding me to another physician's office that may be covering for my doctor, or a physician that I have been referred to.

_____I give my permission for my pharmacy to be contacted regarding my medications. My pharmacy is _____________________________(pharmacy/city).

I will notify this office in writing (verbal will not be accepted) if there is any change in my above permission.

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Name:______________________________ Date:______________________

Medical History

What is the reason for your visit today? Check any/All that apply

- ☐ Well woman annual gyn
- ☐ Birth control options
- ☐ Abnormal bleeding
- ☐ Vaginal discharge/odor
- ☐ Vulvar pain/itching
- ☐ Pelvic pain
- ☐ Fibroid management
- ☐ Menopause symptoms
- ☐ Surgery consult
- ☐ Second opinion
- ☐ Abnormal pap smear
- ☐ Other: ______________________

Current Medications

Name	Dose/Rate/Frequency

Personal Medical History (Check all that apply)

☐ Acid Reflux	☐ Diabetes	☐ Seizures
☐ Anemia	☐ Headaches/migraines	☐ Sexually transmitted infection
☐ Anxiety/Depression	☐ Heart disease	☐ Stroke
☐ Arthritis	☐ Heart attack	☐ Thyroid Disease
☐ Asthma	☐ Hemorrhoids	☐ Tuberculosis
☐ Bleeding disorders	☐ Hepatitis	List any other conditions
☐ Blood clots	☐ High cholesterol	☐
☐ Cancer-Breast	☐ High blood pressure	☐
☐ Cancer-Ovarian	☐ HIV	☐
☐ Cancer-Uterine	☐ Kidney disease	☐
☐ Cancer-Lung	☐ Liver disease	☐
☐ Cancer-other	☐ Osteoporosis	☐

Allergies

Name	Reaction

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GYN History

Are you still having a period? ☐Yes ☐No

If yes, fill out this section	If no, fill out this section
Age at first period?	At what age did you stop having a period?
Last menstrual period?	What was the reason? Check all that apply
Are periods regular? ☐Yes ☐No	☐Menopause
How many days do you bleed?	☐Hysterectomy
How often do periods occur?	☐Unknown
Are periods ☐light ☐moderate ☐heavy	Other (Please write in)
Are periods painful? ☐yes ☐no	☐

Birth Control Method (Check any that apply)

☐None ☐ Nexplanon ☐NuvaRing
☐Diaphragm ☐Depo Provera injection ☐Essure
☐Condoms ☐Natural Family Planning ☐Other ____________________
☐Birth control pills ☐Birth Control Patch ☐IUD ____________________
☐Vasectomy ☐Tubal ligation IUD brand name

Last pap smear? ____________ Was it normal? ☐Yes ☐No
Have you ever had an abnormal pap smear? ☐Yes ☐No
Last mammogram? ____________ Was it normal? ☐Yes ☐No
Last colonoscopy? ____________ Was it normal? ☐Yes ☐No
Last bone density scan? ____________ Was it normal? ☐Yes ☐No

Are you currently sexually active? ☐Yes ☐No
Sexual preference ☐Men ☐Women ☐Both
How many partners do you currently have? ____________________
How many lifetime partners? ____________________

Do you have a history of the following sexually transmitted diseases?

☐HPV (Human Papillomavirus) ☐Gonorrhea
☐HSV (Herpes simplex virus) ☐HIV (Human Immunodeficiency Virus)
☐Chlamydia ☐ Trichomoniasis (Trich)

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OB History

Pregnancies

Total Pregnancies	Full Term	Pre-Term	Ectopic	Abortion Induced	Miscarriage	Total living Children	Multiple Births
List complete information							
Month	Year	Delivery	C-section	Vaginal	Sex	Weight	
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Surgical History (Please list any surgeries you have had)		
Date	Type	Reason for surgery

Family History

Condition	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Anemia	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Cancer-Breast	☐	☐	☐	☐	☐	☐
Cancer-uterine	☐	☐	☐	☐	☐	☐
Cancer-Colon	☐	☐	☐	☐	☐	☐
Cancer-Lung	☐	☐	☐	☐	☐	☐
Cancer-other	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid disorder	☐	☐	☐	☐	☐	☐
Other (write in)						

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Social History

Are you on any diet?	☐Yes	☐No					
Do you exercise?	☐Yes	☐No					
Do you wear your seatbelt?	☐Yes	☐No					
Do you drink caffeine?	☐Yes	☐No					
Do you drink alcohol?	☐Yes	☐No	How many per week?				
Have you used tobacco?	☐Yes, currently	☐Yes, quit	How much per day?		How many years?		☐No
Do you use any of these?	☐Marijuana	☐Cocaine	☐Heroin	☐LSD	☐Mushrooms	☐Ecstasy	
☐Other "uppers"			☐Other "downers"				

Review of Systems

Check any that apply.

Constitution	**Endocrine**	**Gastrointestinal**	**Urinary**	**Central Nervous System**
☐Fatigue	☐Cold intolerance	☐Nausea	☐Pain/burning	☐Migraine Headaches
☐Fever	☐Heat intolerance	☐Vomiting	☐Frequent	☐Weakness/numbness
☐Weight change	☐Glucose/Sugar problems	☐Diarrhea	☐Urgency	
☐Unplanned weight gain	☐Hair loss	☐Constipation	☐Blood in urine	
☐Unplanned weight loss	☐Excessive hair growth	☐Blood in stool	☐UTI's/infection	
		☐Tarry stool	☐Incontinence	
		☐Abdominal pain		
		☐Bloating		
		☐Changes in stool		
		☐Leakage of stool		
Gynecologic	**Mood**	**Hematological**	**Skin**	**Other**
☐Abnormal Discharge	☐Suicidal thoughts	☐Immune compromised	☐Rash	☐Insomnia
☐Odor	☐Thoughts of hurting others	☐Bruise easily		☐ Difficulty sleeping
☐Burning/discomfort	☐Decreased interest in things	☐Bleed easily		☐Hot flashes
☐Vaginal dryness	☐Anxiety			☐Night sweats
☐Vaginal itching	☐Depression			
☐Genital lesions/bump	☐Irritability			
☐Pain with intercourse				
☐yeast infections				
☐breast issues				

Please list any other issues/concerns you are having that you wish to discuss:____
____
____
____
____.

Signature:____ Date:____________________