PHOENIX WOMEN'S CLINICS

INTAKE FORM

Date: _____ **Location:** ☐ 7th Street ☐ McDowell ☐ Hope Mobile

Identifying Data (please print)

Name: *Last:* _____ *First:* _____

Date of Birth: *MM / DD / YEAR* ____ / ____ / _____ *Age:* _____

Street Address: _____ **Zip:** _____

Phone: ( ) _____ - _____ *Consent to Call or Text* ☒

Email: _____ @ _____

Reason for Visit: ☐ Urine Pregnancy test ☐ Blood Pregnancy test ☐ Prenatal Consult ☐ Ultrasound ☐ Implant Removal ☐ Infection Check ☐ UTI testing ☐ STI/STD test ☐ Well-woman Exam ☐ Breast exam ☐ Other

Problems Today: _____

Preferred Pharmacy: _____
Name *Address or major cross streets*

First visit to PWC clinic? ☐ No ☐ Yes

How did you hear about us? ☐ Radio ☐ Google/online ☐ Clinic/Agency ☐ Friend/Family ☐ Signage ☐ Other: _____

Demographic Data:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Cohabitation

Family Size: _____ *(Total # in family)*

Monthly Income: ☐ $0-$5,000 ☐ $5,001-$10K ☐ $10,001-$15K ☐ $15,001-$20K

Race/Ethnicity: ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian **Religion:** _____

Have Health Ins? ☐ Yes ☐ No

Last year of school completed: _____

Occupation: _____

Patient History:

Allergies: ☐ None Known or List: _____

Medications: ☐ None or List: _____

Family History: ***Parents:*** ☐ None ☐ Unknown ☐ Cancer ☐ Diabetes ☐ Heart ☐ Thyroid ☐ Other: _____
Grandparents: ☐ None ☐ Unknown ☐ Cancer ☐ Diabetes ☐ Heart ☐ Thyroid ☐ Other: _____

Social History:
☐ **Alcohol** ☐ None - or - Type: _____ Amount: _____
☐ **Tobacco** ☐ None - or - Type: _____ Amount: _____
☐ **Drugs** ☐ None - or - Type: _____ Amount: _____

Number of Sexual partners in the last 12 months: _____

Birth Control Methods Used: ☐ Pill ☐ Condom ☐ IUD ☐ Implant ☐ Depo shot ☐ NuvaRing ☐ Tubal Ligation ☐ Withdrawal ☐ NFP ☐ Other: _____

History of Domestic Abuse: ☐ No ☐ Yes

Surgical History: (*Do not include pregnancies*) ☐ **None**

	Year	Illness or Operation		Description
1.	_____	_____	☐ Complications	_____
2.	_____	_____	☐ Complications	_____
3.	_____	_____	☐ Complications	_____

Gynecological History:

If pregnant, intention: ☐ carry to term ☐ abortion ☐ adoption ☐ undecided

Last menstrual period: ____ / ____ / _____ **Are periods regular:** ☐ No ☐ Yes

Last sexual intercourse: ____ / ____ /

Last Pap Smear: ____ / ____ / _____ **Abnormal?** ☐ No ☐ Yes: ***Year:*** _____ ***Treatment:*** _____

Most recent Mammogram ____ / ____ / _____ **Abnormal?** ☐ No ☐ Yes: ***Year:*** _____ ***Treatment:*** _____

HPV vaccine/Gardasil: ☐ No ☐ Yes

Blood Type: ☐ Unknown ☐ Type: _____ ☐ Pos / ☐ Neg

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Obstetric History/Past Pregnancies: ☐ **None** **# of Pregnancies:** _____

	Year								
1.	_____	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living	☐ Complications
2.	_____	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living	☐ Complications
3.	_____	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living	☐ Complications
4.	_____	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living	☐ Complications
5.	_____	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living	☐ Complications
6.	_____	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living	☐ Complications
7.	_____	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living	☐ Complications

8 or more, ***Use Additional Form***

Are you currently breast feeding? ☐ No ☐ Yes

Have you ever used the morning-after pill? ☐ No ☐ Yes: ***Date:*** _____

Past Medical History:

Drug/Latex Allergies/Reactions:	☐ No	☐ Yes	Birth Defects for Inherited Disease	☐ No	☐ Yes
Breast problem:	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Female or Sexual Problems	☐ No	☐ Yes	Diabetes:	☐ No	☐ Yes
Infertility	☐ No	☐ Yes	Endometriosis:	☐ No	☐ Yes
Sexually Transmitted Infections	☐ No	☐ Yes	Hypertension:	☐ No	☐ Yes
Sexual Abuse	☐ No	☐ Yes	Psychiatric Illness:	☐ No	☐ Yes
Depression/Postpartum depression	☐ No	☐ Yes	Thyroid Problems:	☐ No	☐ Yes

Other: _____

Phoenix Women's Clinic is not an emergency clinic and does not have a 24-hour answering service.

PLEASE READ AND SIGN AUTHORIZATION FOR SERVICES

- I hereby request Phoenix Women's Clinic to perform a pregnancy test and counseling. I understand that the results of the urine pregnancy test are 98% accurate according to the manufacturer. The earlier the test is done the greater the chance of error. I also understand that a pregnancy test **does not** constitute a clinic diagnosis of pregnancy. I hereby give my full consent to receive services and waive and release Phoenix Women's Clinic and its employees and volunteers from any and all liability arising out of, or connected with, this pregnancy test and particularly with regard to any errors based on this test.
- I hereby request services at Phoenix Women's Clinic for medical treatment and counseling. I understand that Phoenix Women's Clinic medical services are provided by a nurse practitioner, nurse and/or volunteer physicians. I understand that the scope of Phoenix Women's Clinic services is limited, and that if follow-up care is needed I will be referred to appropriate health care providers. I further understand it is my responsibility to obtain any follow-up care.
- A limited ultrasound exam may be recommended, which can be done at Phoenix Women's Clinics. The ultrasound will be done only to confirm an intrauterine pregnancy and to determine fetal age. The ultrasound accuracy may vary up to 2 weeks. This procedure does not identify an ectopic pregnancy (a pregnancy developing inside the fallopian tubes) nor abnormalities of the reproductive organs or of the fetus.
- The counseling provided is not intended as a substitute for professional counseling.
- I understand that communication by text, phone or letter may be deemed necessary at the sole discretion of Phoenix Women's Clinic, and I hereby give permission for that contact to occur.
- I hereby give my full consent to receive medical services and waive and release any and all claims of any kind that I, my baby, my legal representatives, heirs and/or family members could have against Phoenix Women's Clinics, medical personnel, directors, officials, employees and volunteers. I expressly agree that this waiver and release of indemnity contract is intended to be as broad and inclusive as permitted by the laws of Arizona and also that if a portion of the same is held invalid, it is agreed that the remainder of the agreement shall continue in full force and legal effect.
- ***Privacy Notice:*** I understand that the staff of Phoenix Women's Clinic will have access to my confidential clinic records to provide for my medical care and for statistical purposes. My records will not be released to any agency or individual without my expressed permission, except as mandated by law. A patient copy of the Privacy Notice is available upon request.

I have read, understand, and agree with the above:

Patient Signature: _____ Date: _____ Print Name: _____

Witness: _____ Date: _____

Phoenix Women's Clinic Staff