Heather M. Metchick, M.D.
Coastal Women's Health

433 North Causeway
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New Patient Questionnaire

Name:	Phone #	Age:	Marital Status: S M D W

Reason for Visit:

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Colonoscopy		Gardasil		Bone Density	
Pap Test		Mammogram			

Was last pap: ☐ Normal ☐ Abnormal Any previous abnormal Pap date: _____ Treatment: _____

PAST MEDICAL HISTORY: *please check (X) ALL areas that apply to you.*

☐ Arthritis	☐ Hepatitis	☐ Phlebitis	☐ Stomach problems
☐ Asthma	☐ Heart disease	☐ Seizures/epilespsy	☐ Thyroid disease
☐ Anemia/blood disorder	☐ High blood pressure	☐ Serious injuries	☐ Urinary incontinence
☐ Bowel disorders	☐ Kidney/bladder problems	☐ Severe headaches	☐ Other
☐ Diabetes	☐ Mitral valve prolapse	☐ Skin disease	

Vaginal Infections - History of: ☐ Yeast ☐ Trichomonas ☐ Chlamydia ☐ Herpes ☐ Gonorrhea ☐ Other

SURGERIES: *(excluding pregnancy)*

Year	Description

SOCIAL HISTORY:

Smoking: ☐ Yes ☐ No (# cigs per day?) Alcohol: ☐ Yes ☐ No _____ Drinks/Week Street drugs: ☐ Yes ☐ No

Caffeine: Tea/Coffee _____ cups/day Colas _____ cans/day

Exercise: ☐ None _____ times per week Activity:

Sexual History: ☐ Satisfactory ☐ Uncomfortable ☐ Wish to discuss

Domestic Abuse: ☐ Yes ☐ No ☐ Wish to discuss

MENSTRUAL HISTORY:

Age of 1st period _____ Date of last period (1st day) _____ Period interval (1st day to 1st day) # of days _____

Cramps: ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe Medication for cramps _____

Duration of bleeding _____ Menopausal - Yes, I am ☐ Pre ☐ Post or No ☐ I have had a hysterectomy

Contraceptive History: Current Method: Past Methods:

OBSTETRICAL HISTORY:

Total Preg: _____ Full Term Births: _____ Premature Births: _____ No. of Abortions Induced: _____

No. of Abortions: Spontanteous _____ Ectopic Births _____ Multiple Births (twins) _____ Living Children _____

Month/Day/Year	Sex	Type of Delivery
1)		
2)		
3)		
4)		
5)		
6)		

MEDICATION:	Frequency of Dose	MEDICATION:	Frequency of Dose

DRUG ALLERGIES:	REACTION	DRUG ALLERGIES:	REACTION

FAMILY HISTORY: *Have any of your close relatives had any of the following conditions?*

Condition:	Relation to you	Maternal/Paternal	Condition:	Relation to you	Maternal/Paternal
☐ Blood disorder			☐ High blood pressure		
☐ Breast cancer			☐ Kidney disease		
☐ Cancer			☐ Lung disease		
☐ Diabetes			☐ Ovarian cancer		
☐ Heart attack			☐ Stroke		

PLEASE CHECK (✓) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU CURRENTLY

CONSTITUTIONAL
- ☐ Weight Loss
- ☐ Weight gain
- ☐ Fever
- ☐ Fatigue

BREASTS
- ☐ Pain in breast
- ☐ Discharge
- ☐ Masses
- ☐ Implants

CARDIOVASCULAR
- ☐ Painful breathing
- ☐ Chest pain
- ☐ Difficult breathing on exertion
- ☐ Swelling of legs
- ☐ Palpitations of heart

RESPIRATORY
- ☐ Wheezing
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Cough, chronic

GASTROINTESTINAL
- ☐ Frequent diarrhea
- ☐ Bloody stool
- ☐ Nausea/vomiting
- ☐ Constipation

GENITOURINARY
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency of urination
- ☐ Incomplete emptying
- ☐ Stress incontinence
- ☐ Abnormal periods
- ☐ Painful intercourse

SKIN
- ☐ Rash
- ☐ Ulcers

NEUROLOGIC
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble walking

ENDOCRINE
- ☐ Dry skin
- ☐ Abnormal thirst
- ☐ Hot flashes

PSYCHIATRIC
- ☐ Depression
- ☐ Frequent crying

HEMATOLOGICAL/LYMPHATIC
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Easy bleeding

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Name _____ ***Age*** _____ ***Date of Birth*** _____

Address _____

City _____ ***St*** _____ ***Zip*** _____

Home Phone _____ ***Cell Phone*** _____ ***Work Phone*** _____

Primary Physician _____ ***Referred by*** _____

Email _____

Emergency Contact _____ ***Relation*** _____ ***Phone*** _____

Please list anyone with who we are able to discuss your care, finances, etc.:

Name _____ ***Relationship*** _____

Name _____ ***Relationship*** _____

Name _____ ***Relationship*** _____

RELEASE OF INFORMATION, BENEFIT ASSIGMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Heather M. Metchick, M.D. to release information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photo copy of my signature to be used to process my insurance/Medicare claim for period of **LIFETIME.** I claim any insurance benefits due to me for services rendered by Heather M. Metchick, M.D. and authorize and direct my carrier to issue payment directly to Heather M. Metchick, M.D. regardless of insurance benefits, if any. I understand that I am fully financially responsible for all fees incurred, and I agree to pay such fees in full.The insurance information furnished represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose of pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by a carrier. I authorize Heather M. Metchick, M.D. and her staff to call my home or other alternate numbers and leave a message on voice mail or in person in reference to any items that assist the practice, such as appointment reminders, insurance items, and any calls pertaining to my clinical care. A copy of the Notice of Privacy Practices has been given to me.

Patient Signature _____ Date _____

(Parent or Guardian if Minor)

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CONSENT FOR TREATMENT

I hereby give consent to Heather M. Metchick, M.D. to provide and perform medical care, procedures, order tests, prescribe medications and other services as are considered necessary or beneficial by Heather M. Metchick, M.D., for my health and well being.

I have been informed that my insurance plan may not cover routine Well Woman Annual exams. I have been informed that Medicare covers Well Woman Annual exams once every two years. If my insurance company determines that a particular service is not "reasonable and necessary", my insurance company may deny my claim and I will be responsible for the cost of today's visit.
I have also been informed Well Woman Annual exams and problem visits are considered by my insurance company two separate visits. Therefore I will be responsible for any co-payment, co-insurance, or deductibles incurred at time of service.

_____ _____

Patient Name (printed) Date

_____ _____

Patient Signature Date