

**Whole Woman's Health of Beaumont**  
3470 Fannin Street, Suite 3 \* Beaumont, TX 77701  
(409) 833-9207 \* (800) 666-9207

**Patient Information**

We need the following information for your visit here. We use this for medical purposes only. We take every precaution to provide confidentiality. Please do not leave anything blank. We do not give any information, to you or anyone else, over the phone unless we can positively identify you.

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Best time: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_ Dept: \_\_\_\_\_  
Student: NO / YES      Where: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ email address: \_\_\_\_\_

**Emergency Contact Information: "Every patient must fill this out completely!"**

Please list someone you would want us to contact in case of emergency.  
If you are under the age of 18, this must be a parent or guardian.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

**Patient Contact Information**

Federal privacy rules require that you tell us how to contact you with information, lab results, appointment changes, and other information that is crucial to your care with us. Please check all that apply:

**Call me at my home phone number and say:**

- "Whole Woman's Health Called"
- "your doctor's office called"
- "Jane called" (our code for call the clinic)

**Call me on my cell phone number and say:**

- "Whole Woman's Health"
- "Your doctor's office called"
- "Jane called" (our code for call the clinic)

**The best way to mail information to me is:**

**Home address:**  Clinic Envelope  Plain Envelope      **Work address:**  Clinic Envelope  Plain Envelope

There may be critical situations that arise which require Whole Woman's Health to make contact with you quickly. If unable to do so, Whole Woman's Health may send certified mail to your home address as a way to make direct contact.

**Menstrual History**

How old were you when you first started having periods? \_\_\_\_\_  
What is the length of your menstrual period? \_\_\_\_\_  
(# of days from the start of one period to the start of the next period)  
Are your periods ever more than a month apart? \_\_\_\_\_  
What is the usual length of your period? (# days of bleeding) \_\_\_\_\_  
Do you have pains or cramps with your period? If yes, what treatment \_\_\_\_\_  
What was the first day of your last period, and was it normal? \_\_\_\_\_

**Pregnancy History**

Total number of times you have been pregnant (including today). \_\_\_\_\_  
Number of vaginal deliveries. \_\_\_\_\_ Complications? \_\_\_\_\_  
Number of C-section's. \_\_\_\_\_ Complications? \_\_\_\_\_  
Number of miscarriages. \_\_\_\_\_ Complications? \_\_\_\_\_  
Number of abortions. \_\_\_\_\_ Complications? \_\_\_\_\_  
Has a pregnancy been confirmed by any of the following:  
 Urine test at home?       Pelvic Exam? Where? \_\_\_\_\_  
 Urine test at a clinic? Where? \_\_\_\_\_  
 Blood test at a clinic? Where? \_\_\_\_\_

**Problems you are experiencing today**

Vaginal discharge bothering you? Yes / No  
Bleeding or pain during or after sex? Yes / No  
Any other problems? \_\_\_\_\_

If yes, which itching, burning, or bad odor with discharge?  
\_\_\_\_\_

**Personal Medical History (please check all that apply)**

- Anemia or "low blood" / Sickle Cell
- Asthma; do you use an inhaler? \_\_\_\_\_
- Bad chest pains or unusual shortness of breath
- Bladder or kidney infection
- Bleeding between periods
- Blood clots in you legs or lungs (thrombophlebitis or pulmonary embolus)
- Cancer of your uterus, vagina or breast(s)
- Chlamydia, gonorrhea or other vaginal infection
- Diabetes/hypoglycemia/sugar in your urine
- Eating disorder
- Epilepsy, convulsions, seizures or fits
- Heart disease
- Heart murmur, Meds? \_\_\_\_\_
- Hepatitis
- High blood pressure/hypertension
- High Cholesterol
- Allergic to any medications? If yes, please list? \_\_\_\_\_
- Do you take any medications? If yes, please list? \_\_\_\_\_
- Have you ever been hospitalized? If yes, please describe and date? \_\_\_\_\_
- Have you ever had any surgeries? If yes, please describe and date? \_\_\_\_\_
- Have you ever had a PAP Smear? Yes / No When was your last PAP Smear? \_\_\_\_\_ Normal / Abnormal
- What is your Bloodtype (ex: O+, A-, B+)? \_\_\_\_\_
- Please list any other health concerns not listed above; \_\_\_\_\_

- HIV positive or AIDS
- Infection in your tubes or uterus
- Loss of sight or fuzzy vision
- Lumps in your breast(s) or discharge
- Lupus / Autoimmune Disease
- Migraine headaches or severe headaches often
- Mononucleosis
- Pelvic inflammatory disease (PID)
- Recreational Drug Use, which/last use \_\_\_\_\_
- Psychiatric / Nervous Disorder
- Rheumatic fever
- Depression/Suicidal tendencies, Meds? \_\_\_\_\_
- Thyroid Disease, Meds? \_\_\_\_\_
- Trichomonas, Garnerella or bacterial vaginosis
- Tuberculosis
- Yeast infection
- Do you smoke cigarettes? If yes, how many? \_\_\_\_\_

**Family Medical History (please check all that apply)**

- Diabetes or hypoglycemia
- High blood pressure / hypertension
- Blood clots in legs or lungs (thrombophlebitis or pulmonary embolus)
- Lumps in breast or breast cancer
- Uterine cancer or cervical cancer
- Cancer of any other kind
- Stroke
- Sickle cell anemia: trait or disease
- Heart attack

I understand that everything regarding me as a patient here is confidential. I give permission for the above information to be used if medically necessary. I understand that if I am under the age of 18, additional medical services at another facility may require parental / guardian consent. I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forward above have been answered to my satisfaction. I will not hold my physician, or any other member of this staff, responsible for any error or omissions that I may have made in the completion of this form. I also understand that my medical records may be released according to state law.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have received and understand the Patient Privacy Notice:

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_