

Whole Woman's Health of McAllen

802 South Main * McAllen TX 78501

(956) 686-2137 * (866) 682-1200

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:

Please list someone you would want us to contact in case of emergency.

Name: _____ Relationship: _____

Address: _____

Home Phone: (____) _____ Work Phone: (____) _____

Is this person aware of the nature of your care with us? NO / YES If no, is it OK to discuss with them in case of emergency? NO / YES

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"

Call me on my cell phone number and say:

- "Whole Woman's Health called"
 "Your doctor's office called"

The best way to mail information to me is: 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?
 Urine test at a clinic? Where? _____
 Blood test at a clinic? Where? _____

- Pelvic Exam? Where? _____
 None

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: _____