Today's Date:_____

HOMETOWN FAMILY MEDICINE
AND WOMEN'S HEALTH

Dr. Scott C. Wyman, MD
Dr. Courtney I. Hathaway, MD
Diana M. Podlecki, PA-C
Jeanne K. Bloom, F.N.P.
Brandi Glibbery F.N.P.

Name: _____

Date of Birth: _____Social Security Number: _____

Physical Address: _____

Mailing Address: _____

City & State: _____ Zip Code: _____

Phone #: Cell: _____ Other: _____

Email address: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Please indicate whether you would like to have a nurse present during your exam.

Check one and initial.

[ ] Requested
[ ] Denied

X _____

Referred by: _____

Primary Care Provider (if applicable): _____

Your Preferred Pharmacy: _____

Spouses, Guarantor or Significant Other Information

Name: _____ Date of Birth: _____

Occupation:_____Employer: _____

Phone #: Home: _____Cell: _____

May we disclose health/billing information to this person? ☐ Yes ☐ No

Insurance Information

Primary: _____ Secondary: _____
ID#: _____ ID#: _____
Group#: _____ Group#: _____
Subscriber:_____ Subscriber: _____
Subscriber Date of Birth:_____Subscriber Date of Birth:_____

Authorization to release medical information to insurance company or another physician care for patient. I realize I am responsible for all charges regardless of insurance. I hereby authorize my insurance benefits to be paid directly to the undersigned physician.

Patient's Signature: _____

OB/GYN- IF APPLICABLE

FAMILY AND PERSONAL HEALTH HISTORY

Please complete the following information as accurate as possible. If you cannot remember specific details, please give the best estimate. Thank you.

Name:	**DOB:**	**Date:**

GYNECOLOGIC HISTORY:

Problems with Menstrual Periods?___No ___Yes **Details:** _____

Frequency? (26 days? 28 days?)_____**Date of Last Menstrual Period**_______________

Age of First Period? _____ **Date of Positive Pregnancy Test** _______________

Date of Last Pap____________
History of Abnormal Pap?___No ___Yes **Details:**

History of Breast Disease?___No ___Yes **Details:**

What is your current method of Contraception?___None___Pill___IUD___Other
Sterilization___No___Yes **Details:**

History of Endometriosis?____No___Yes **What treatments?**

History of Infertility?____No____Yes **What tests and/or treatments?**

HPV Vaccine? ____No____Yes **Year:** _____

History of Sexually Transmitted Disease?___No ___Chlamydia___Herpes ___Genital Warts (HPV) ___Gonorrhea___Other:
History of AlcoholAbuse?___No___Yes **If yes, details:**

OBSTETRIC HISTORY- (Please include miscarriage/abortion history)

Year	City/State	Pregnancy Duration	Hours in Labor	Sex	Birth Weight	Type of Delivery	Complications

SURGICAL HISTORY AND HOSPITALIZATIONS

Year	City/State	Type of Surgery/Reason for Hospitalization	Complications

HEALTH MAINTENANCE

Cholesterol Screening: ___ No___Yes
Results: **Date:**
Mammogram:___No___Yes
Results: Date:
Colonoscopy:___No___Yes
Results: Date:
Bone Density Scan:___ No___Yes
Results: Date:
Tobacco Use:___No___Yes **Packs per day_____Quit?_____Date**_______________
Alcohol Use:____ No___Yes **Drinks per week._____**
Exercise:____Never____1-3 times a week____2-4 times a month
Vitamins and/or Calcium Supplements:___No___Yes
Recreational Drug Use:___ No___Yes **Have you used or shared needles?**___No___Yes

CURRENT MEDICATIONS

No Medications _____

(PLEASE USE THE BACK OF THIS PAGE FOR MORE ROOM IF NEEDED)

Medications	Dosage	Frequency	Prescribing Physician

MEDICAL ALLERGIES

No Known Allergies _____

Medication	Reaction

PERSONAL & FAMILY HISTORY: (SELF, FAMILY MEMBER, AND ANY DETAILS YOU CAN REMEMBER)

***Are you Adopted? No Yes**

History	Family If yes, who?	Self	Details
High Blood Pressure or vascular disease (High Cholesterol, Varicose Veins, Blood Clots in Legs)			
Heart Disease (Irregular beats, Heart Attack, Valve Issues, etc.)			
Pulmonary Disease (Asthma, Emphysema, COPD, TB)			
Diabetes (Type 1 or Type 2, Insulin treatment)			
Thyroid Disease (Underactive, Overactive, Goiters, Graves' Disease,)			
Gastrointestinal Disease (Hepatitis, Gallbladder problems, Acid Reflux, Crohns .)			
Kidney and Bladder Problems (Infections, Stones, Bladder Control Problems)			
Neurological Problems (Migraines, Seizures, Strokes, Paralysis)			
Hematologic (Blood**) Disease** (Anemia, Leukemia, Clotting Problems)			
Musculoskeletal Problems (Arthritis, Joint or Spine problems, Osteoporosis)			
Emotional or Psychiatric Problems (PMS, Anxiety, Depression, Bipolar, Suicide)			
Female Cancers (Breast, Cervix, Uterus, Ovaries)			
Other Cancers (Colon, Lungs, Prostate)			
Genetic (inherited**) or Congenital Diseases** (Down Syndrome, Cystic Fibrosis, Hemophilia)			
Other Autoimmune disease such as lupus etc.)			

HAVE YOU HAD ANY GENETIC SCREENING OR DIAGNOSIS OF:

	Yes	No		Yes	No
Age Over 35			**Muscular Dystrophy**		
Thalassemia (Italian, Greek, Mediterranean, Or Asian Background)			**Cystic Fibrosis**		
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			**Huntington Chorea**		
Congenital Heart Defect			**Learning disability/Cognitive delay/Autism** (if yes was person for Fragile X)		
Down Syndrome			**Other Inherited Genetic or Chromosomal Disorder**		
Tay-Sachs (EG, Jewish, Cajun, French Canadian)			**Maternal Metabolic Disorder** (E.G. Insulin-Dependent Diabetes, PKU)		
Sickle cell Disease or Trait (African)			**Patient or Baby's Father had a Child with Birth Defects** (Not Listed)		
Hemophilia			**Recurrent Pregnancy Loss, or a Stillbirth**		

PERSONAL HISTORY

	Yes	No		Yes	No
History of Domestic Violence			**Perpetrator Name:**		
Perpetrator in the Home			**Restraining Order in Place**		

SEXUAL PRACTICES

	Yes	No		
Sexually Active			**Orientation Homo, Hetero, or Bi-Sexual**	
Practice Safe Sex			**Number of Current Partners**	
Other:			**Number of Partners you have been within your lifetime**	
			Gender Identity	

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F):_____ **Today's Date(MM/DD/YY):**_____ **Health Care Provider:**_____

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.
If yes, indicate family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	☒ Y ○ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	○ Y ○ N				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○ Y ○ N				
2 or more people on the same side of my family (can include me) with **breast cancer**, one at age 50 or younger	○ Y ○ N				
Ovarian (peritoneal/fallopian tube) cancer at any age	○ Y ○ N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	○ Y ○ N				
3 or more of these cancers on same side of my family at any age: **pancreatic, breast**, or **aggressive prostate*** *Gleason Score ≥7	○ Y ○ N				
Male **breast cancer** at any age	○ Y ○ N				
Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age	○ Y ○ N				
Pancreatic cancer or aggressive prostate cancer and one relative with **breast cancer at age 50 or younger**	○ Y ○ N				
20 or more **colon/rectal polyps** found in 1 person throughout their lifetime. Specify number_____	○ Y ○ N				
Colon/rectal or **Endometrial (uterine) cancer** before age 50	○ Y ○ N				
Personal history of **Endometrial (uterine) cancer** at any age‡	○ Y ○ N				
TWO individuals on the same side of my family (can include me): at least 1 with **colon/rectal *or* endometrial (uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	○ Y ○ N				
THREE OR MORE individuals on the same side of my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a colon/rectal or **endometrial (uterine) cancer**	○ Y ○ N				

‡ **PREMM$_{[1,2,6]}$ Score ≥ 5%**
* **Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).**

Have you or a family member had genetic testing for a **hereditary cancer syndrome**?	○ Y ○ N	If yes, Who?_____ What gene(s)?_____ What was the result? _____

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If YES, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®^{PLUS} with Myriad myRisk ☐ COLARIS *AP*®^{PLUS} with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update ☐ Other:_____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com

HOMETOWN FAMILY MEDICINE AND WOMEN'S HEALTH

EMERGENCY CONTACT RELEASE OF INFORMATION

Emergency Contact Form / HIPAA In case of an emergency, who should we contact on your behalf?

1. _____relationship: _____Ph: _____

2. _____relationship: _____Ph: _____

3. Do you have a living will or advance directive? Yes _____No _____

Does the document specify someone to have medical power of attorney (POA) for your affairs (ie; someone designated to make decisions about your care and consent to procedures if you are unable to)? Yes ____No____

Named POA: _____

Has this individual actively assumed the role as your decision maker or POA? Yes ____No ____

Do you give our office permission to discuss your medical condition and information about your care with any family members or close friends? Yes _____No _____

If yes, please provide names and contact information below if known:

__Same as #1 listed above.

__Same as #2 listed above.

□ Name: _____relationship:_____Ph: _____

□Name: _____relationship:_____Ph: _____

□ Name:_____relationship:_____Ph:_____

The phone number listed as your primary phone in our records is the one we will use for appointment reminders, to convey results of your labwork, or to contact you regarding billing issues. Please notify our receptionist in the event of a change in your primary contact number.

Is there an alternate number that we may try if we need to contact you regarding a schedule change or appointment reminder? _____□ cell □work □ landline □family member _____

May we leave personal information on your answering machine or voicemail? Yes ____No ____

May we use your email to contact you, give appointment reminders, or send medical info? Yes ____No ____

X_____ Date_____

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name:

DOB:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Credit/Debit Card on File, No Show & 24-Hour Cancelation Policy

Hometown Family Medicine and Women's Health has implemented a credit card policy.

We kindly request our patients' or guardian/guarantor for a credit/debit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service.

Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion of the balance due. You will receive one bill which will show what will be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, just hold onto the statement for your records and your card will be charged. Additionally, a receipt will be emailed to you once the card is charged.

<u>No show and 24-hour cancelations</u>

Because it is difficult to fill cancelled appointments without sufficient notice, appointments cancelled without 24-hour notice and missed appointments will be charged a $50 fee to the card on file.

If you have any questions about the card-on-file payment method or balances due, please do not hesitate to contact our office.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CV: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Hometown Medicine and Women's Health to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date