Physicians & Surgeons
Gynecology, Obstetrics & Aesthetic Medicine

Salem Women's Clinic Mission Statement: ***To provide high quality medical care to the women of Salem in a caring and nurturing environment.***

Dear: _____ Date: _____

Welcome to Salem Women's Clinic, Inc., the first all women medical group in Salem. Dr. Harmon opened Salem Women's Clinic in 1991, and at that time she wrote a mission statement that embodied her dream. We constantly strive to keep this mission statement evident in every aspect of your care.
We have moved to our newly remodeled office at 1395 Liberty St SE. A map is included but please feel free to call for directions.

This packet of information includes forms needed for your appointment on _____.
Please fill them out and bring them with you to your appointment, along with your current insurance card and a photo ID.

- **General Office Information**:
  - **Office Hours:** 8:00 am to 5:00 pm Monday thru Friday.
  - **Parking:** Parking at our office is located off of Myers Street.
  - **Appointment Cancellation:** Please give 24 hours notice to avoid a $25.00 cancellation fee.

We look forward to your visit with us and hope you will find it both comfortable and rewarding. We encourage input on how we can improve our services to our patients. Please let us know of any suggestions you may have.

Thank you for choosing Salem Women's Clinic for your women's health care needs.

Sincerely,

Elizebeth Harmon, M.D. & Staff

Salem Women's Clinic, Inc.

PATIENT INFORMATION RECORD (Please print)

Last Name: _____ First: _____ Middle Initial: _____

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

DOB: _____ Social Security #: _____ e-mail: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Driver's License #: _____

Primary Care Physician: _____Phone #: _____

Who Referred You to our Practice? _____

Employer Name: _____Phone #: _____

Employer Address: _____
City State Zip

Spouse's Name: _____ Phone #: _____

Spouse's Employer: _____ Phone #: _____

In case of emergency contact: (name): _____ Phone #: _____

Nearest friend or relative not residing with you: _____

Relationship to Patient: _____Phone #: _____

INSURANCE BILLING INFORMATION:

PRIMARY INS	EFFECTIVE DATE	SECONDARY INS	EFFECTIVE DATE
CLAIMS ADDRESS	PHONE #	CLAIMS ADDRESS	PHONE #
POLICY or ID #	GROUP NUMBERS/UNION AND LOCAL	POLICY or ID #	GROUP NUMBERS/UNION AND LOCAL
SUBSCRIBER NAME	RELATIONSHIP TO PT	SUBSCRIBER NAME	RELATIONSHIP TO PT
Subscriber Address	Subscribers DOB:	Subscriber Address	Subscribers DOB:
EMPLOYER	PHONE #	EMPLOYER	PHONE #

IS PATIENT A MINOR? _____ IF YES, Responsible Persons Name: (Please print) _____

Relationship to patient: _____ PH#: _____

I hereby authorize the Salem Women's Clinic to speak with the above name person regarding my account.

SIGN: _____Date: _____

I consent to treatment necessary for the care of the above named patient or myself. I authorize the release of all medical records/information to the referring, referred, and/or family physician. I authorize the health care providers of Salem Women's Clinic, Inc. (SWC) to release my medical information that is needed to determine insurance benefits or benefits payable to the Heath Care Finance Administration and its agents. I hereby assign to the SWC, all monies to be paid by said insurance company for services provided by SWC, but not to exceed my indebtedness to said clinic.

_____ _____ _____

Print Patient's Name Responsible Party Signature Date

Account #: _____ Provider: _____

MEDICAL HISTORY

Name _____ Address _____

Date of Birth _____ Age _____ Phone _____

Occupation _____ Date _____

Marital Status _____

PROBLEM or REASON FOR VISIT _____

_____

PREGNANCY RECORD

Never pregnant_____ Full-term_____ Premature_____ Miscarriages_____ Abortions_____ Living Children_____

(Include miscarriages and abortions

YEAR	HOSPITAL OF DELIVERY	DUR. OF PREG.	DUR. OF LABOR	DELIVERY VAG/C SEC.	ANESTHESIA (GEN. SPINAL EPIDURAL, ETC.)	WT.	SEX	HEALTH OF INFANT AT BIRTH	COMPLICATIONS
List in sequence									

MENSTRUAL HISTORY

First day of last menstrual period _____ Age at first period _____

Number of days between 1st day of each period _____ Days flow lasts _____

Number of tampons/pads on heaviest days _____

Place an X beside any syptoms that apply to you.

_____Recent change in periods
_____Last period was unusual
_____Bleeding between periods
_____Bleeding after intercourse
_____Pass blood clots
_____Do not menstruate
_____Hot flashes
_____Night sweats
_____Difficulty sleeping

_____ Pain associated with periods
How many days does pain last? _____
Does pain require medication? _____
_____ Periods cause you to miss work/school
_____ Bloating or swelling before periods
_____ Irritable before periods
_____ Emotional instability
_____ Crying spells
_____ Vaginal dryness

If you do not menstruate, is it due to _____ Pregnancy _____ Menopause _____ Hysterectomy _____ Other

Do you think you may be starting menopause? _____ Yes _____ No

_____

_____

_____

_____

BIRTH CONTROL - Place an X where applicable to you.

_____ Not sexuall active
_____ Desire pregnancy
_____ Permanently sterilized
_____ Vasectomy
_____ Tubal Ligation
_____ Hysterectomy
_____ Other

List contraception methods previously used

Current method of contraception:
_____ Withdrawal
_____ Rhythm
_____ Foam suppositories
_____ Condoms
_____ Norplant - Year inserted _____
_____ IUD Type _____ Year inserted _____
_____ Depoprovera
_____ Diaphragm
_____ Cervical Cap

_____ Birth control pills
Name of pill _____
Dose _____ Year started _____

If you plan to use or are now using birth control pills, place an X by any problems you have now or had in the past:

_____ High blood sugar
_____ High blood pressure
_____ Hepatitis or jaundice
_____ Blood clots in veins
_____ Migraine headaches
_____ Other

SEXUAL HISTORY

_____ Not sexually active
_____ Pain with intercourse
_____ Sexual problem
_____ Desire sexual information
_____ New sexual partner since last exam

PAP SMEARS AND INFECTIONS

Date of last pap smear _____ Results _____ Where performed _____

_____ Previous abnormal paps
_____ Mother took hormones during your pregnancy

Current Problems
_____ Vaginal discharge
_____ Vaginal irritation
_____ Sores around vaginal area

Past Problems
_____ Infection of uterus, ovaries or tubes
_____ Sexually transmitted diseases
_____ Recurrent vaginal infections
_____ Herpes
_____ Genital warts or condyloma

URINARY SYSTEM

Place an X beside any symptoms that apply to you.

_____ No trouble with urinating now
_____ Trouble with urinating now
_____ Burning
_____ Blood in urine
_____ Frequency
_____ Urgency
_____ Get up at night to empty bladder
_____ Bladder infection in Past
How many the past year? _____

_____ Lose Urine unintentionally
This is a problem for you with
_____ Coughing, straining
_____ Without warning
_____ Requires change of clothing or protection
_____ Previous bladder surgery

BREASTS

Place an X beside any symptoms that apply to you.

_____ Concerned about lump now
_____ Lump removed in the past
_____ Pain in breast
_____ Change in breast size
_____ Previous mammograms or x-rays of breasts
_____ Do not check breasts routinely
_____ Family history of breast problems

PAST HISTORY

HOSPITAL ADDMISSIONS/OPERATIONS/INJURIES: (not for pregnacies)

Year/Age	Hospital	Operation or reason for hospitalization	Problems or complications

Childhood:

_____ German measles
_____ Rubella vaccine
_____ Mumps
_____ Rheumatic or scarlet fever
_____ Polio

Other Health Aspects:

_____ Blood transfusions
_____ Injuries or fractures
_____ Disability

Chronic Diseases:

_____ Tuberculosis
_____ Hepatitis or jaundice
_____ Phlebitis
_____ Blood clots in lung
_____ Nervous breakdown
_____ Insurance application refused
_____ Diabetes
_____ Thyroid disease
_____ Heart disease
_____ High blood pressure
_____ Anemia
_____ Asthma
_____ Lung disease
_____ Stomach or gallbladder problems
_____ Colitis or bowel problems
_____ Kidney disease
_____ Cancer
_____ Seizures, epilepsy
_____ Other

_____

_____

_____

CURRENT SYMPTOMS

Place an X by those that apply to you NOW.

_____ Weigh gain/loss
_____ Heat or cold intolerance
_____ Oily/dry skin
_____ Unusual hair growth or loss
_____ Worrisome moles
_____ Complexion problems
_____ Trouble with eyes/seeing
_____ Trouble with ears/hearing
_____ Chronic nose or sinus trouble
_____ Constant cough
_____ Cough up phlegm or blood
_____ Ulcers
_____ Food intolerance
_____ Frequent loose stools
_____ Chronic constipation
_____ Routine laxative use
_____ Trouble breathing
_____ Chest pains
_____ Irregular heartbeat
_____ Swelling of hands/feet (if not pregnant)
_____ Stomach problems
_____ Hemorrhoid trouble
_____ Blood in stools
_____ Painful joints
_____ Prolonged bleeding after cut or extraction
_____ Bruise easily
_____ Numbness of arms/legs
_____ Frequent severe headaches
_____ Paralysis of arms/legs
_____ Feel nervous of anxious
_____ Feel depressed
_____ Marital difficulties

_____

_____

_____

PERSONAL HISTORY

_____ Smoke cigarettes
How many per day? _____
For how long? _____

_____ Socially use alcoholic beverages
_____ Excessive/problem alcohol use
_____ Narcotics/IV drug use
_____ Cocaine use

_____ Smoke marijuana
_____ Exercise regularly
How often _____
_____ Special diet
Type _____

MEDICATIONS

Place an X beside those that apply to you. _____ I have taken female hormones in the past. Dates _____

_____ Take **no** medications currently _____ I have taken cortisone pills or shots in the past. Dates _____

List all drugs currently used (prescription and non-prescription)

DRUG	DOSAGE	DATE STARTED

Drug Allergies:

_____ None known

DRUG	REACTION

Family Health (Place ✓ if affected)

	Current age	Good health now	Cancer or malignancy	Arthritis	Allergies or asthma	Heart attacks	High blood pressure	Strokes	Kidney disease	Sugar diabetes	Nerve disease (cerebral palsy, epilepsy, ms)	Psychiatric problems (nervous breakdowns)	Blood disease or anemia (Hemophilia, leukemia)	Tuberculosis	Birth defects or inherited disease (club foot, cleft lip, etc.)	Cause of Death	Age
Mother																	
Father																	
Sisters																	
Brothers																	
Maternal grandfather																	
grandmother																	
Paternal grandfather																	
grandmother																	
Husband																	
Children																	
Other																	

_____

_____

SALEM WOMEN'S CLINIC, INC.
HIPAA ACKNOWLEDGMENT AND CONSENT

I understand that Salem Women's Clinic (referred to below as "SWC") will use and disclose **health information** about me. I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree that SWC may **use and disclose** my health information in order to:

make decisions about and plan for my care and treatment;
refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how SWC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of SWC, and my rights regarding my health information. Our Notice of Privacy Practices is also available at our website: salemwomensclinic.com. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that SWC is not required by law to agree to such requests. I authorize my personal medical information to be released to me at my:

☐ Cell#_____ OK to leave confidential info? YES ☐ NO ☐

☐ Home#_____ OK to leave confidential info? YES ☐ NO ☐

☐ Work#_____ OK to leave confidential info? YES ☐ NO ☐

☐ SWC Portal _____ OK to leave confidential info? YES ☐ NO ☐

****

I also authorize my personal medical information to be released to:

☐ spouse/partner_____@#_____

☐ parent or other: _____ @ #_____

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.

Patient name:_____ DOB_____

Signature:_____ Date:_____

By: _____ Date: _____
(Patient representative)

12/12 kb
3/12 kb
4/10 kb
10//09
04/02