ESTABLISHED QUESTIONNAIRE

DATE: _____ NAME: _____ DOB:

1. Reason for today's visit: _____ ANNUAL/WELLNESS _____ PROBLEM (please give a brief description if problem)

_____

2. When was the first day of your last period? _____

3. Are you currently having any urinary symptoms? _____ yes _____ no

4. What is the name and location of the pharmacy you would like listed in your chart?

_____

5. What medications (with doses) are you currently taking?

_____

6. Please list any DRUG ALLERGIES: _____

7. Since your last visit, have you had any changes to your Medical History/Family History or had any Surgeries? ___yes ___no

If yes, please list: _____

REVIEW OF SYMPTOMS

PLEASE CIRCLE ANY OF THE FOLLOWING YOU MAY BE EXPERIENCING

GENERAL:	Fevers Chills Weight Gain Weight Loss Changes in Appetite
EYES:	Change in Vision Pain Double Vision Eye Infection
EARS, NOSE & THROAT:	Hearing Loss Mouth Ulcers Seasonal Allergies Nasal Congestion
CARDIOVASCULAR:	Palpitations Difficulty Breathing Chest Pain Shortness of Breath with Exercise
RESPIRATORY:	Chronic Cough Wheezing Coughing Blood Shortness of Breath Snoring
GASTROINTESTINAL:	Heartburn Nausea Vomiting Pain Swelling Constipation Diarrhea Blood in Stool Hemorrhoids Fecal Incontinence
GYNECOLOGICAL:	Heavy Bleeding Irregular Bleeding Painful Intercourse Painful Periods Vaginal Itching Vaginal Discharge
MENOPAUSE:	Decreased Libido Night Sweats Hot Flashes Bleeding after Menopause
GENITOURINARY:	Burning with Urination Pain with Urination Blood in Urine Urinary Frequency Leaking Urine Retaining Urine
BREAST:	Lumps Pain Redness Nipple Discharge
MUSCULOSCKELETAL:	Bone Pain Joint Pain Joint Swelling Muscle Aches History of Bone Fracture
SKIN:	Rashes Changing Moles Dry Skin Fine lines or wrinkles around eyes, mouth and/or forehead
NEUROLOGICAL:	Paralysis Arm/Leg Weakness Loss of Speech Memory Loss Vision Loss Vertigo Headaches Dizziness
PSYCHIATRIC:	Anxiety Sadness Moodiness Irritability

HIPAA Release of Information Authorization

Please list below the Authorized Representative(s) that we may speak with about your Healthcare. You may at any time, with written authorization, change or revoke this authorization. By completing this form please be aware that you authorize the Healthcare Providers, and staff of Physicians to Women to discuss all your Healthcare needs, billing issues, and questions with those listed below.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand if I wish to obtain a copy of *The Notice of Privacy Practices* that provides a more complete description of information uses and disclosures, one will be made available for me. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their notice and practices and prior to implantation will make a copy available. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name (Printed) _____ Date of Birth _____

Patient Signature _____

Date _____

PHYSICIANS TO WOMEN
1815 S Kanner Hwy, Stuart, FL 34994
1945 SE Port St Lucie Blvd, Port St Lucie, FL 34952
1304 N Lawnwood Cir, Fort Pierce, FL 34950
Phone: (772) 288-2992 Fax: (772) 288-2999

Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia—are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

- A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.
- Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems; vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.
- The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine, and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.
- The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).
- There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____ ____/____/_____
Signature Date

I understand that my provider is involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

_____ ____/____/_____
Signature Date

Created 05-18-2021