CHICAGO women's HEALTH GROUP

New Patient Demographics

Last Name: ____________________ First Name: ____________________ Middle: ________________

Nickname/Preferred Name: ____________________ Date of Birth: ________________

Social Security Number: _______________________

Address: ____

City: ______________________ State: ______________________ Zip Code: ________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Please circle the number where we may leave a detailed, confidential message.

Email Address: ____________________________

Preferred Pharmacy Name: ______________________

Pharmacy Address: ____________________________

City: ______________________ State: ______________________ Zip Code: _____________

How were you referred to our office?

Patient (name): _________________________

Facility (full name): ______________________

Physician (first and last name): ______________________

Social media (which platform): _____________________

Employer Information

Name: _____________________________________

City: ______________________ State:______________________ Zip Code: _____________

Position: _____________________________________ Status: Full-Time ☐ Part-Time ☐

Emergency Contact

Name: _______________________

Relationship: __________________

Phone Number: ________________

Your insurance is necessary for us to process any insurance claims and to ensure payments of service rendered.

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Chicago Women's Health Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature (Patient and/or guardian if minor): ____________________________ Date: _____________

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New Patient History

Name: ______________________________ Date: __________

Please help us provide you the best healthcare by completing this short questionnaire.

What brings you to the office today?______________________________

What are your gender pronouns?
- She, her, hers, herself
- He, him, his, himself
- They, them, theirs, themselves
- Ze, hir, hirs, hirself
- Just my name, please
- Other ______________

What is your ethnicity/ancestry?
- Ashkenazi Jewish
- Asian
- Black/African American
- French Canadian
- Hispanic/Latinx
- Mediterranean
- Native American or Alaska Native
- Pacific Islander or Native Hawaiian
- Sephardic Jewish
- White/Caucasian
- Other ______________

What medications are you currently taking? (Please list each medication and your current dose.)

1. ______________
2. ______________
3. ______________
4. ______________

Do you have any of the following health problems?

Asthma	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid issues	☐ Yes	☐ No
Migraines/Headaches	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Postpartum depression	☐ Yes	☐ No

Other: ______________

Do you have allergies to any medications? ☐ Yes ☐ No

If yes, please list ______________

Have you ever had surgery? (If yes, please list.)

1. ______________
2. ______________
3. ______________
4. ______________

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Do you have a family history of any of the following? (If yes, please list which family member)

Breast cancer	☐ Yes	☐ No ________	High cholesterol	☐ Yes	☐ No ________
Ovarian cancer	☐ Yes	☐ No ________	Heart disease	☐ Yes	☐ No ________
Uterine cancer	☐ Yes	☐ No ________	Diabetes	☐ Yes	☐ No ________
Colon cancer	☐ Yes	☐ No ________	Stroke	☐ Yes	☐ No ________
Pancreatic cancer	☐ Yes	☐ No ________	Thyroid disorders	☐ Yes	☐ No ________
Melanoma	☐ Yes	☐ No ________	Bleeding disorders	☐ Yes	☐ No ________
High blood pressure	☐ Yes	☐ No ________	Blood clotting disorders	☐ Yes	☐ No ________

Social History

Do you drink Alcohol? Yes ☐ No ☐

If yes, how many drinks per week? ____

Have you ever felt the need to cut down on drinking? Yes ☐ No ☐

Do you smoke Cigarettes or Vape? Yes ☐ No ☐

If yes, how many per day? ________

Do you use marijuana? Yes ☐ No ☐

Do you use any other recreational drugs? Yes ☐ No ☐

If yes, please specify __________

What is your occupation?______________________________

Do you exercise? Please specify how often and what type: ________________

Are you currently:

Single ☐ In a Relationship ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐

Obstetric & Gynecologic History

Date of your last menstrual period ________

Do you have any concerns about your periods? ____________________

Do you use a method of contraception? Yes ☐ No ☐

If yes, please indicate which type: ______________________

Do you have sex with men, women, or both? _____________________

Do you have a history of any sexually transmitted infections? Yes ☐ No ☐

If yes, please indicate which ones: ______________________

Date of your last Pap Smear ________

Do you have a history of abnormal pap smears? Yes ☐ No ☐

Did you receive the HPV / Gardasil vaccine? Yes ☐ No ☐

Date of your last mammogram ________

Have you had an abnormal mammogram? Yes ☐ No ☐

Have you had a breast biopsy or surgery? Yes ☐ No ☐

Have you ever been pregnant? Yes ☐ No ☐

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Genetic Screening Questionnaire

Name: ____ Date: ______________

Instructions: Please answer the following questions to the best of your ability. Your healthcare provider will review the information given at your visit. Thank you.

1. Will you be 35 years or older when the baby is due? ☐ Yes ☐ No

2. Age of father/sperm donor of the child? _____

3. What is your ethnicity/ancestry?

- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Black/African American
- ☐ French Canadian
- ☐ Hispanic/Latinx
- ☐ Mediterranean
- ☐ Native American or Alaska Native
- ☐ Pacific Islander or Native Hawaiian
- ☐ Sephardic Jewish
- ☐ White/Caucasian
- ☐ Other ___________

4. What is the ethnicity/ancestry of the father/sperm donor?

- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Black/African American
- ☐ French Canadian
- ☐ Hispanic/Latinx
- ☐ Mediterranean
- ☐ Native American or Alaska Native
- ☐ Pacific Islander or Native Hawaiian
- ☐ Sephardic Jewish
- ☐ White/Caucasian
- ☐ Other ___________

5. Do you have any religious reasons that you cannot receive blood products/transfusions? ☐ Yes ☐ No

6. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

- Neural Tube Defect, i.e., Spina Bifida (myelomeningocele or open spine), anencephaly ☐ Yes ☐ No
- Congenital Heart Defect ☐ Yes ☐ No
- Down Syndrome ☐ Yes ☐ No
- Tay-Sachs ☐ Yes ☐ No
- Canavan Disease ☐ Yes ☐ No
- Sickle Cell Disease ☐ Yes ☐ No
- Hemophilia ☐ Yes ☐ No
- Muscular Dystrophy ☐ Yes ☐ No
- Cystic Fibrosis ☐ Yes ☐ No

7. Do you or the baby's father have any close relatives with intellectual disability or autism? ☐ Yes ☐ No

8. Do you or the baby's father have any close relatives with Fragile X? ☐ Yes ☐ No

9. Do you or the baby's father have diabetes, metabolic syndrome, celiac disease, PKU, or any other disorder that prevents you from metabolizing food without assistance? ☐ Yes ☐ No

10. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal disorder not listed above? ☐ Yes ☐ No

11. In this or any previous relationships, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? ☐ Yes ☐ No

12. Have you ever had chicken pox? ☐ Yes ☐ No

13. Have you or the baby's father ever had or been treated for a sexually transmitted disease, such as chlamydia, herpes, gonorrhea, syphilis? ☐ Yes ☐ No

14. Have you or the baby's father ever had a positive test for HIV or been exposed to AIDS? ☐ Yes ☐ No

15. Have you ever had or tested positive for tuberculosis? ☐ Yes ☐ No

16. Are you and the baby's father related (besides marriage)? ☐ Yes ☐ No

17. Have you or the baby's father ever had hepatitis? ☐ Yes ☐ No

18. Do you work in the healthcare field? ☐ Yes ☐ No

19. Do you have cats? ☐ Yes ☐ No

20. Do you garden? ☐ Yes ☐ No

21. Have you traveled outside the country during pregnancy? ☐ Yes ☐ No

22. Have you had gestational diabetes in a previous pregnancy? ☐ Yes ☐ No

23. Have you taken any prescribed medications, over-the-counter medications, recreational drugs, or alcohol since your last menstrual period? If yes, please list medication and dose. ☐ Yes ☐ No

____

____

24. Have you had any previous pregnancies with a different practice? ☐ Yes ☐ No

If yes: ____________________

Date of delivery: ____________________

How many weeks when delivered: ____________________

Vaginal or Caesarean section: ____________________

Weight of baby: ____________________

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: ______________________ Date: ____________

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. 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.	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

add columns ______ + ______ + ______

Total Score ______

10. 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 ______

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CHICAGO women's HEALTH GROUP

PATIENT FINANCIAL POLICY

Thank you for choosing Chicago Women's Health Group as your healthcare provider. Our primary mission is to provide our patients with outstanding medical care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

You will be asked to fill out a new patient information form at your first visit. Please notify our office at your follow-up visit(s) if any of the information has changed.

All self-pay services must be paid prior to your visit. Please see the billing department when you arrive for your appointment.

As a courtesy to you, we file your claims to your insurance company. Amounts not covered by your insurance are your responsibility. All copayments must be paid at the time of your visit. If you are not prepared to pay your copay, your appointment may be rescheduled. Payment of your balance after insurance is expected within 30 days unless payment arrangements have been made with our billing department. We accept cash, checks, Visa, MasterCard, Discover, and American Express. There is a $25 fee for checks returned due to insufficient funds. If you do not understand your statement or have questions regarding your balance, please feel free to contact our billing department at 312-943-0282 option 3 for clarification.

ADDITIONAL NOTES

Appointments must be canceled or rescheduled at least 24 hours prior to your appointment time or you will be subject to a $50 fee. We have reserved an appointment time for you and most likely will not be able to fill it at the last minute.

If you have any questions regarding billing, please contact our billing department at 312-943-0282 option 3 from 8:00 a.m. to 4:00 p.m. Additionally, you are always welcome to stop by our office when you are here for an appointment. We are happy to assist you!

Sign: ______________________________ Date: ________________