CHICAGO women's HEALTH GROUP

New Patient Demographics

Last Name: _____ First Name: _____ Middle: _____

Nickname/Preferred Name: _____ Date of Birth: _____

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

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

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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)

	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 _____

211 East Chicago Avenue Suite 1200 Chicago, Illinois 60611 phone 312-943-0282 fax 312-943-0284

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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: _____

211 East Chicago Avenue Suite 1200 Chicago, Illinois 60611 phone 312-943-0282 fax 312-943-0284