PROVIDENCE
Medical Group
Hood River

Providence Medical Group-Hood River Women's Clinic
917 11th St., Suite 200
Hood River, OR 97031
541-387-8940 | fax 541-387-8908

Appointment date _____

Appointment time _____

Welcome to the Providence Medical Group-Hood River Women's Clinic. We welcome you as a patient and thank you for choosing us to participate in your health care.

We provide full service gynecology services, including ultrasound, major and endoscopic surgery, basic infertility care, urinary incontinence treatment and surgery, as well as normal and high risk obstetrics.

For your first appointment, please arrive **15 minutes prior to your scheduled appointment to complete registration process.** Additionally, we ask that you bring all medications you are currently taking, including supplements and over-the-counter medications, in the original bottles, so that they charted correctly upon your initial visit. **Please request the last six months of chart notes from your current primary care physician and the last two years of specialty care including labs and X-rays**.

Please see the enclosed information regarding your first appointment.

We request that you refrain from wearing perfumes or colognes, as we see many patients who are susceptible to allergic reactions to scents.

Please bring the following to your appointment:

- Photo ID
- Medical insurance card
- Completed enclosed forms
- All current medications, in the original bottles

If you have any questions, please call us at 541-387-8940.

We look forward to seeing you soon.

PROVIDENCE
Medical Group
Hood River

Providence Medical Group- Hood River Women's Clinic
917 11th St., Suite 200
Hood River, OR 97031
541-387-8940 | fax 541-387-8908

History form:
Please fill out your medical history as completely as possible.

Medications:
Please bring in all your current medications in the original bottles.

Record release form:
If you are transferring from another care provider, please request your records be transferred to your new doctor before to your appointment. You will find this form, Authorization for Release of Medical Records, in your packet.

If you need a copy of your lab results, you can sign a two-year release of records in your physician's office.

Cancellation policy:
We ask that you contact our office at least 24 hours before to your scheduled appointment if you need to cancel or reschedule. This allows appointments for other patients.

Before your appointments:
Please arrive 15 minutes before your appointment to allow time for registration. Remember to transfer your medical records from your previous provider.

Notice:
If you arrive more than 10 minutes past your scheduled appointment time, you may be asked to reschedule your appointment.

Billing Questions: 541-387-8219 or 877-215-7833

Medical History Form
Women's health

PROVIDENCE Medical Group Hood River

Date:

Name

Email

First Middle Last

MARITAL STATUS: (circle one) Single Married Widowed Divorced Separated Committed ____years

DATE OF BIRTH:

Primary Care Physician:

REASON FOR YOUR APPOINTMENT:

Last Menstrual Period:

SURGERY HISTORY

Type of Surgery, Year, Physician: (include tonsils, appendix)

OB/GYN HISTORY

Total Number of Pregnancies:

Full Term: Premature:

Miscarriages: Abortions:

Last Pap Smear: Results:

Last Mammogram: Results:

Any Abnormal Paps? Year:

Any reaction to anesthetic? Yes No

If yes, what?

ANY CERVICAL TREATMENT OR PROCEDURES:

HOSPITALIZATIONS/SERIOUS ILLNESS/INJURIES

Condition Year

HISTORY OF : (CIRCLE)

Chlamydia Gonorrhea Herpes Genital Warts

If born pior to 1960 did your mother take DES?

Current Number of Partners:

Birth Control Method Currently Used:

PAST MEDICAL HISTORY

Other Methods Used:

Cancer type? Yes No

Age at first Intercourse:

Frequent ear, nose, throat or sinus infection? Yes No

Period starts every_____days and lasts_____days

Heart problems/Murmur? Yes No

Self Breast Exams? Monthly Occasionally Never

High Blood Pressure? Yes No

Last Cholesterol: Month Year

TB/Positive TB skin test? Yes No

Rubella Status: immunized non-immunized unknown

Asthma/Chronic Bronchitis? Yes No

Stomach Ulcers? Yes No

(CIRCLE)

Gallbladder Disease? Yes No

History of Breast Cysts, Lumps? Yes No

Hepatitis? If yes , what type Yes No

Do you have painful periods? Yes No

Colonoscopy Yes No

Do you have pain with intercourse? Yes No

Diabetes? Yes No

Do you have irregular bleeding? Yes No

Thyroid Disease? Yes No

Do you have bleeding between periods? Yes No

Migraine Headaches? Yes No

Do you have abnormal vaginal discharge? Yes No

Anemia? Yes No

Do you have vaginal itching? Yes No

Varicose Veins/Blood clots in veins? Yes No

Do you have menopausal symptoms (hot flashes, mood changes, irregular periods, etc…) Yes No

Frequent Kidney/Bladder Infections? Yes No

Infections in your tubes or ovaries? Yes No

Do you have any urinary symptoms (uncontrolled loss of Urine, frequency, burning, etc…) Yes No

Depression/Mental Illness? Yes No

Eating Disorders? Yes No

Blood Transfusions? Yes No

Have you ever been abused or molested? Yes No

Allergies	Reaction

Do you have a Latex allergy?_____

Current Medications including vitamins and herbal supplements

Habits	Amount per day
Cigarettes	
Alcohol/Beer/Wine	
Cocaine/Marijuana/ IV drugs	
Caffeine	

Diet: (circle one)

Fair Good Excellent

Family History

Your Blood Relatives	Past or Present illness		Relation to you
Breast Cancer	Yes	No	
Ovarian Cancer	Yes	No	
Uterine Cancer	Yes	No	
Colon Cancer	Yes	No	
Heart Disease	Yes	No	
Diabetes	Yes	No	
Osteoporosis	Yes	No	
High Blood Pressure	Yes	No	
Stroke	Yes	No	
Bleeding Disorder	Yes	No	
Other	Yes	No	

Pregnancy History

Year	Vaginal or Cesarean	Sex and Weight	Complications

Name_____ Date of Birth_____

Pregnancy History Record

PROVIDENCE Medical Group Hood River

Year	Delivery location	Number of weeks pregnant	Vaginal delivery or c-section	Number of hours in labor	Pain management methods	Complications	Name Weight Gender

Patient Name_____

Authorization for Release of Medical Records

PROVIDENCE Medical Group Hood River

Patient's Name: _____
First *Middle* *Last*

Date of Birth: ____/____/____ **Social Security Number:** _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION		
FROM:	Name (Medical Provider holding records): _____ Address: _____	
TO:	Name:	Phone #
	Address:	Fax #

The purpose of the release is: ❑ Diagnostic Evaluation ❑ Reimbursement ☑ Follow-Up Care ❑ Legal ❑ Other

The following information may be released: ☑ Clinical notes (Re: _____)

☑ Laboratory Reports (LAST 2 YEARS) ☑ Immunization Records ☑ Medication Records ☑ X-Ray Reports

☑ Other: EKG'S, PATHOLOGY REPORTS, SPECIAL STUDIES, SPECIALISTS' CONSULTS, HOSPITAL RECORDS INCLUDING ER VISITS, ADMITS, H&P'S, IN PT. CONSULTS, SURGERY/PROCEDURE REPORTS, AND DISCHARGE SUMMARIES (LAST six MONTHS ONLY)

Information may be released for dates of service from SEE ABOVE through SEE ABOVE

This authorization expires six months from the date signed or: _____ (specified expiration date)

I have read the above and fully understand its contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

_____ (Signature of patient or representative)

_____ Relationship (if signed by representative)

_____ Date Signed

_____ Witness (optional)

Driver's License/Identification _____

I do ____/do not ____ specifically consent to transmission of my medical records via a facsimile (fax) machine. Signature Date	I recognize that the information disclosed may contain drug/alcohol information that is protected by Federal and State law. I specifically consent to disclosure of such information Signature Date
I recognize that the information disclosed may contain mental health information that is protected by Federal and State Law. I specifically consent to disclosure of such information Signature Date	I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV / AIDS testing information. I specifically consent to disclosure of such information Signature Date

This authorization may be revoked at any time unless prior action has been taken as a result of this form. Records obtained as authorized by this consent for information release will be maintained in accordance with Federal confidentiality regulations (Title 42 of the Federal Register) which prohibits re-disclosure.

Medical Record # _____

Providence
Prescription Refill Policy

PROVIDENCE
Medical Group
Hood River

Please request **all** prescription refills through your pharmacy:

- Your pharmacy's phone number and your prescription number should be on your prescription bottle.
- Call your pharmacy even if you have no refills remaining. Your pharmacy will contact your doctor for authorization.
- If you are changing pharmacies, your new pharmacy can contact your previous pharmacy and transfer your existing prescriptions. Your new pharmacy will contact our office if refills are needed.

Call your doctor's office for a refill **only** if:

- Your prescription needs to be picked up in person.
- You have a question about your medication.

Please allow at least 72 hours to approve your refill request, as our refills are processed by a central refill service in Portland.