Cece Huffnagle, RN,NP

303-837-1060 F: 303-830-9398

PATIENT INFORMAITON SHEET

NAME_____ DATE_____

EMAIL_____ BIRTHDATE_____

MARITAL STATUS_____

ADDRESS_____

_____

PHONE_____OK TO LEAVE VM YES ( ) NO ( )

EMPLOYMENT INFORMATION

EMPLOYER_____ OCCUPATION_____

ADDRESS_____

PHONE_____

OTHER INFORMATION

PHARMACY_____ PHONE_____

HOW DID YOU HEAR OF US? _____

ARE YOU CURRENTLY RECEIVING HEALTH CARE FROM OTHER PROFESSIONALS?

IF SO, WHOM? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I understand that I am responsible for payment at the time service is rendered. I also understand that I will be charged $50 for appointments that are not cancelled within 24 hours. I further understand that I will be charged a fee of $25.00 for each returned check.

SIGNATURE_____ DATE_____

GENERAL:

Describe your general state of physical and emotional health:

Major illnesses and injuries:

Operations/Hospitalizations:

How much and in what form do you consume the following:

Tobacco	Alcohol	Caffeine
Recreational drugs	Avg. servings dairy/day	
Avg. servings red meat/week	Snack foods / refined sugars / artificial sweeteners	

Supplements (include dose per day) (If you need more space, please put on a separate piece of paper.)

List any medications you are taking:

Do you exercise regularly? (State frequency and type)

List allergies/reactions to medications, foods, plants, animals, chemicals, etc.

Substance	Reaction

Family History (Give age and state of health or cause of death)

Mother:	Father:
Brothers/Sisters:	
Children:	

For Women:

1st day of last period	Age periods first started
Age at menopause	Length of cycle

Do you have: [ ] irregular periods [ ] severe cramps [ ] spotting [ ] heavy bleeding [ ] premenstrual syndrome

(Check and describe)

Sexually active?	Current form of contraception
Number of pregnancies	Number of births

Any complications? (Describe)

Any other female problems?

Continued on next page

Reason for your appointment:

HAVE YOU HAD?	**Yes**	**No**	If yes, describe
Chronic Fatigue or Weakness			
Fibromyalgia			
Poor or Excessive Appetite			
Unexplained Fevers			
Recent Gain or Loss in Weight			
Chronic Pain			
Recurrent Infection			
Recurrent Bleeding			
Sleep Problems			
Sexual Difficulties			
Emotional Stress			
Addictions			
Digestive Problems			
Any Eye Disease or Impaired Sight			
Any Ear Disease or Hearing Loss			
Trouble with Nose, Sinuses, Mouth, Throat			
Seizures (Convulsions)			
Severe Headaches			
Difficulty Swallowing			
Shortness of Breath			
Frequent Cough			
Coughing up Blood			
Pneumonia			
Asthma			
Heart Attack or Angina			
Chest Pains			
Palpitations (Fluttering Heart)			
Gallstones			
Abdominal Pain			
Ulcers			
Constipation			
Diarrhea			
Blood in Stool			
Hemorrhoids			
Difficulty in Urinating			
Kidney Stones			
Blood in Urine			
Arthritis			
Edema (Swelling)			
Jaundice or Liver Disease			
Tuberculosis			
Diabetes			
High Blood Pressure			
Thyroid Disease			
Skin Disease			
Problems with Nerves			

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Cece Huffnagle, RN NP
The Women's Health and Menopause Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, Cece Huffnagle, RN NP, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations, as described in the Notice of Privacy Practices.

With my consent, The Women's Health and Menopause Center may call my home, work, or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice of carrying out treatment, payment, and healthcare operations, such as appointment reminders, billing questions, and any call pertaining to my clinical care, including but not limited to, exam/lab results.

With my consent, The Women's Health and Menopause Center may fax or mail to my home, work, or other designated location, any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards, result letters, and billing statements.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Cece Huffnagle, RN NP may decline to provide treatment to me.

_____ _____

Patient's Signature Date

_____

Print Name