

Donna Claypool, NP
13359 Isle Drive, Suite 1
Baxter, MN 56425
218-454-8888

Thank you for scheduling an appointment with Donna Claypool, NP on _____ at _____ for a comprehensive women's health assessment. Enclosed you will find a packet of information that needs to be completed for your upcoming appointment. Included in the packet is:

- ✓ A Women's Health Assessment form that needs to be completed prior to arrival for your appointment.
- ✓ A demographic and insurance information form.

If you have any further questions or need to reschedule your appointment, please feel free to contact our office at 218-454-8888.

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1, Baxter, MN 56425
(This information is necessary for our files & will be considered confidential)

PATIENT'S FULL NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ SEX: M F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL _____

PRIMARY PHONE # TO CONTACT YOU: _____

ALTERNATE PHONE #: _____

ALTERNATE PHONE #: _____

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ CONTACT INFO: _____

WOULD YOU LIKE TO HEAR ABOUT UPCOMING SEMINARS, PROMOTIONS, AND SPECIALS
_____yes _____no

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE _____

ID # _____ GROUP # _____

POLICY HOLDER (IF OTHER THAN PATIENT):

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE _____

ID # _____ GROUP # _____

POLICY HOLDER (IF OTHER THAN PATIENT):

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled; to be made on my behalf to Kurtis Waters MD, PA for any services furnished me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance.

This facility does not deny any benefits or service because of race, color, national origin, age gender, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint. In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill.

Signature _____ Date _____
(Legal Guardian if minor)

Women's Health Assessment

Name _____ E-mail Address _____
 Age _____ Date of Birth _____ Referring Physician _____
 Primary Care Physician _____ OB/GYN _____

Who were you referred by / how did you hear about us?

Self Doctor Friend/Family Member _____ Other _____

Height _____ Weight _____ Blood Pressure _____ (taken during assessment)

Are you comfortable with your current weight? No Yes

What would you consider an ideal weight for you? _____ Date of last physical _____

Past Medical History

Have you been diagnosed/treated for:

	No	Yes		No	Yes
Cancer - Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	STD /HIV	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol problem	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

List Surgeries / Pertinent Hospitalizations _____

List Nutritional/Natural Supplements

- vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
 minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
 herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, etc.)
 enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
 nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)
 others (glucosamine, antihistamines, antacids, etc.)

List: _____

List Hormones Previously Taken Date Started Date Stopped Reason

List Prescription Medications

List Medication Allergies _____

Have you had any of the following tests performed?

	No	Yes	Date / Year of Test
Mammography	<input type="checkbox"/>	<input type="checkbox"/>	
PAP Smear	<input type="checkbox"/>	<input type="checkbox"/>	
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Bone Density	<input type="checkbox"/>	<input type="checkbox"/>	

OB/GYN History

How many children do you have? _____ How many pregnancies have you had? _____

Have you had any interrupted pregnancies? No Yes _____

Have you had a hysterectomy? No Yes Date of surgery _____

Have your ovaries been removed? No Yes

Have you had a tubal ligation? No Yes

Have you ever used oral contraceptives? No Yes Any problems? No Yes

If YES, describe any problem(s) _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?
 No Yes If YES, please explain (such as age when this occurred, symptoms, etc ...)

Are you still having menstrual cycles? No Yes

When was your last period? _____

How often? _____

How many days of flow? _____

Bleeding between cycles? No Yes

Do you have, or did you ever have, Premenstrual Syndrome (PMS)? No Yes

If YES, explain symptoms: _____

If menopausal, have you had any spotting or bleeding? No Yes

Past Medical History

Has anyone in your family been diagnosed/treated for:

	No	Yes	Relationship(s)
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	

Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Fibrocystic Breast	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Lifestyle

How many alcoholic drinks do you consume per week? _____ Type of drink _____

How much caffeine do you consume per day? _____

How many diet beverages do you consume per day? _____

Do you smoke? No Yes How much per day? _____ If quit, when? _____

Do you feel you eat healthy? No Yes _____

Do you follow a special diet? No Yes _____

Do you feel your diet is excessive in: Carbohydrates Proteins Fats

Do you exercise? No Yes Number of times per week _____ Type _____

Are you interested in increasing? No Yes Type _____

Marital Status: Married to _____ Significant other _____
 Single Divorced Widowed

Education _____ Occupation _____

Stress

Do you feel stress in your life? No Yes

If YES, please rank the source with 1 being the most stressful.

Physical/health related	
Relationship(s)	
Job related	
Emotional	
Other _____	

Do you feel stress from any relationships (spouse, kids, family, coworkers, and friends) in your life? No Yes

Please explain who / what are the issues: _____

Have you considered counseling? No Yes Would you consider counseling? No Yes

External Self

Are you generally comfortable with your appearance? No Yes

If NO, what are your areas of concern? _____

Are you routinely using a skin care regimen and/or makeup? No Yes

Are you interested in a complimentary consult with an esthetician (skin care specialist) regarding options for skin rejuvenation/maintenance products? No Yes

Are you interested in information or visiting with someone regarding:

- Facial Rejuvenation? No Yes
- Body Rejuvenation? No Yes
- Dental Rejuvenation? No Yes
- Hair Style Options? No Yes

CHECK the degree of severity for any symptoms that apply to you:

	mild	moderate	severe		mild	moderate	severe
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy/Irregular menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluid Retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harder to Reach Climax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body aches/joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breakthrough Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Skin/Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Sex Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fuzzy thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any additional comments or concerns: _____

Patient Signature _____

Date _____

Kurtis Waters MD PA
Riverstone Professional Centre
13359 Isle Drive, Suite 1, Baxter, MN 56425

RELEASE OF INFORMATION

For confidential and legal reasons you are the only one who is authorized to receive information regarding your account. If you wish to authorize a spouse or another person to receive and/or discuss your information please indicate his/her name and relationship below.

I authorize _____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

to receive the following information concerning my account (check all that apply):

- financial information (ex: billing information/ account balances)
- medical information (ex: test results/ patient care/ appointment information)

_____/_____
Patient Signature Date

Print Name: _____ Date of Birth: _____

This release will be valid until the patient revokes authorization by signing and dating below.

I revoke authorization to release my information to the above named person effective date: _____.

Signature: _____