

AUDUBON WOMEN'S MEDICAL ASSOCIATES, P.C.
2240 North Forest Road
Williamsville, NY 14221
(716)-639-4034

**Authorization For Release of Protected Health
Information**

I, _____ Date of Birth: _____
Name (REQUIRED) (REQUIRED)

_____ Daytime Phone: _____
Address (REQUIRED)

Authorize release of my protected health information (PHI) FROM:

Doctor Name: _____ Name: Audubon Women's Medical
Phone Number: _____ **TO** Address: 2240 North Forest Rd
Fax Number: _____ Williamsville, NY 14221
Fax# (716) 929-8940

I understand that I have the right to revoke this authorization at any time but that I must do so in writing.

I am requesting the following information to be disclosed: (REQUIRED-Please specify):

_____ **** Please check here If HIV results are to be sent****

The purpose of this disclosure is (Please specify):

Please be aware that information disclosed pursuant to this authorization is subject to redisclosure by the recipient and is no longer protected by this organization.

_____ Signature (REQUIRED) _____ Date (REQUIRED)

This form is valid for 12 months from the date of signature

AUDUBON WOMEN'S MEDICAL ASSOCIATES, PC
2240 North Forest Road Williamsville, NY 14221
Phone: (716) 639-4034 Fax: (716) 929-8940

NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____

Language _____ Race _____ Ethnicity: (circle one) Hispanic Non-Hispanic
(White, Black, Asian, etc.)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: S M D W SS# _____ E-mail address: _____

Primary Physician: _____ Phone: _____

Physician Address: _____

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

Pharmacy Information

Pharmacy Name/Location/Phone: _____

Insurance Information

Insurance Name: _____ ID#: _____

Subscriber Name: _____

Secondary Insurance

Insurance Name: _____ ID#: _____

Subscriber Name: _____

I hereby authorize Audubon Women's Medical Assoc., PC to release medical and other information relative to services rendered, to perform services necessarily incident to such treatment, and to ensure confidentiality. I hereby authorize payment of medical benefits to Audubon Women's Medical Assoc., PC and I understand that I am financially responsible for charges not covered by my insurance carrier, unless other arrangements have been made.

Signature of Patient and/or Responsible Party

Date

Name: _____

MEDICAL HISTORY

ALLERGIES:

Please list any allergies:

Allergic to Latex? Yes No

CURRENT DAILY MEDICATIONS:

Please cross out any medications you are no longer taking on the list above and list any new medications/supplements:

Medical History:

Cancer	Y	N	Type _____
Heart disease	Y	N	
High Blood Pressure	Y	N	
High Cholesterol	Y	N	
Fibrocystic breast	Y	N	
Kidney Stones/Disease	Y	N	
Diabetes	Y	N	
Fibroids	Y	N	
Endometriosis	Y	N	
Crohn's disease	Y	N	
Thyroid disease	Y	N	
Tuberculosis/Hep B	Y	N	

Surgical History - list surgery and date

Other hospitalizations: _____

Contraceptive Method: (pill, IUD, condoms)

Sexually Active: Y N

Are you currently pregnant? Y N

Partner Preference: (please check one)

___ Men ___ Women ___ Men & Women

Other medical problems/conditions:

Pregnancy: Number of Pregnancies: _____ Number of live births: _____ Multiple births: _____

Complications: _____

Date of Last Menstrual Period _____

Date of Last Pap Smear _____

Date of Last Mammogram _____

Date of Last GYN Exam _____

Date of Last Bone Density _____

Date of Last Colonoscopy _____

Menstrual History: Age of 1st period: _____ Time between periods: _____ Duration: _____
Flow: light moderate heavy (circle one)

Age of menopause: _____ Estrogen replacement: Yes No

Name: _____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Check the appropriate box.

	Yes (Now)	Yes (Past)	No (Never)		Yes (Now)	Yes (Past)	No (Never)
Cardiovascular				Gastrointestinal:			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Skin:				Musculoskeletal:			
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes outbreaks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Respiratory:				Genitourinary:			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine Retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis/COP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent UTIs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
GYN:							
Symptomatic Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Symptomatic Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Night sweat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				