Thank you for choosing Gynecology at Alice Peck Day Memorial Hospital for your gynecologic care. We are located at 9 Alice Peck Day Drive in Lebanon, NH. We have sent this paperwork to you to become a new patient with, to re-establish your care with us or because we have received a referral on your behalf from another medical provider.

In order to help us see patients on time and in an efficient manner, please take a few moments to fill out the enclosed forms. Be as complete as possible.

Once this completed paperwork is received, we will gladly schedule you with the first available appointment.

We look forward to your visit and hope to bring you the highest quality care possible. Thank you for doing your part to assist us in that endeavor.

Dartmouth Health

Alice Peck Day Memorial Hospital

New Patient Intake
Gynecology – Women's Care Center

MRN: _____

NAME: _____

DOB: _____

Two identifiers needed or Patient Label

Patient Name: _____ Date of Birth: _____
(last name, first name, middle initial) Gender: ☐ Male ☐ Female

Preferred Name (what do you prefer we call you, if different than above) _____

Mailing Address: _____
(street) (City/State/Zip Code)

Physical Address (if different from mailing address): _____

Home Phone (primary ☐) _____ Cell Phone: (primary ☐) _____

Have you ever been seen at a Dartmouth Health Facility? ☐ Yes ☐ No ☐ Unsure

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Race: ☐ White ☐ African American ☐ American Indian ☐ Asian
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Social Security Number: _____ Primary Care Provider: _____

Primary Language: _____ e-mail address: _____

Employer: _____ Occupation: _____

Work Phone: _____ Preferred Pharmacy: _____

INSURANCE INFORMATION

Primary Insurance

Plan Name: _____ Policy Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's Gender: ☐ Male ☐ Female Policy Holder's SSN: _____

Policy Holder's Relation to Patient: _____ Effective Date of Coverage: _____

Do you have another insurance coverage? ☐ Yes ☐ No

Secondary Insurance

Plan Name: _____ Policy Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's Gender: ☐ Male ☐ Female Policy Holder's SSN: _____

Policy Holder's Relation to Patient: _____ Effective Date of Coverage: _____

Dartmouth Health

Alice Peck Day Memorial Hospital

New Patient Intake
Gynecology – Women's Care Center

MRN: _____

NAME: _____

DOB: _____

Two identifiers needed or Patient Label

PARENT/GUARDIAN or PERSON RESPONSIBLE FOR BILLS (complete only if different from patient)

Name: _____ Social Security Number: _____

Mailing Address: _____
(street) (City/State/Zip Code)

Home Phone: _____ Relation to Patient: _____

PRIOR HEALTH CARE / ADVANCE DIRECTIVES

Last Primary Healthcare Provider (name & location): _____

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Durable Power of Attorney for Health Care? ☐ Yes ☐ No

If yes, who? _____ Relationship to Patient: _____

Phone Number: _____

*If Dartmouth Health does not have a copy of your Living will or Durable Power of Attorney for Health Care, please provide us with a copy to be added to your electronic medical record.

Dartmouth Health

Alice Peck Day Memorial Hospital

New Patient Intake
Gynecology – Women's Care Center

MRN: _____

NAME: _____

DOB: _____

Two identifiers needed or Patient Label

I attest that the information I am answering below is true and correct to the best of my belief.

_____

Patient Signature **Date**

Referred here by: _____

PAST MEDICAL HISTORY

Have you ever had any of these conditions – check all that apply

Breast Conditions:
- ☐ Abnormal Mammogram
- ☐ Breast Cancer ☐ Left ☐ Right
- ☐ Breast Implants
- ☐ Fibrocystic Breasts
- ☐ Other: _____

Gynecology Problems:
- ☐ Abnormal Pap Smear
- ☐ Cervical Cancer (neoplasm)
- ☐ Dysmenorrhea (painful menses/period)
- ☐ Endometrial (Uterine) Cancer
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Herpes
- ☐ Human Papilloma Virus Infection (HPV)
- ☐ Ovarian Cancer
- ☐ Ovarian Cysts
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Sexually Transmitted Disease (STD)
- ☐ Vaginal Cancer (neoplasm)
- ☐ Vulvar Cancer (neoplasm)
- ☐ Other: _____

Blood (Hematologic) Disorders:
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Clotting Disorder
- ☐ Sickle Cell Trait or Disease
- ☐ Thalassemia
- ☐ Other: _____

Endocrine (glandular) Disorders:
- ☐ Diabetes – Type I (insulin-dependent)
- ☐ Diabetes – Type II
- ☐ Pituitary Gland Disorder
- ☐ Thyroid disease (hypo or hyper)
- ☐ High Cholesterol
- ☐ Other: _____

Immune System Diseases:
- ☐ Chronic Fatigue Syndrome
- ☐ Sinus Allergies
- ☐ Systemic Lupus
- ☐ Rheumatoid Arthritis
- ☐ Other: _____

Gastrointestinal (GI) Problems:
- ☐ Colitis, Ulcerative
- ☐ Crohn's Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Irritable Bowel Syndrome
- ☐ Other: _____

Neurologic Disorders:
- ☐ Common Migraines
- ☐ Headaches (other)
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder (Epilepsy)
- ☐ TIA or Stroke
- ☐ Other: _____

MRN: _____
NAME: _____
DOB: _____
Two identifiers needed or Patient Label

Have you ever had any of these conditions – check all that apply *(continued)*

Heart or Circulation Conditions (Cardiovascular):
☐ Congenital Heart Disease
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ CVA (Stroke)
☐ Hypertension (High Blood Pressure)
☐ Irregular Heart Beat
☐ Mitral Valve Disorders (MVP)
☐ Pulmonary Embolism (blood clot in lung)
☐ Thrombophlebitis (blood clot in extremity-arm/leg)
☐ Other: _____

Musculoskeletal Disorders:
☐ Arthritis
☐ Joint Pain
☐ Fibromyalgia
☐ Osteopenia
☐ Osteoporosis
☐ Scoliosis
☐ Systemic Lupus Erythematosus
☐ Other: _____

Psychiatric or Emotional Conditions:
☐ ADHD/ADD
☐ Bipolar Disorder (Manic-Depressive)
☐ Major Depression
☐ Obsessive Compulsive Disorder (OCD)
☐ Postpartum Depression
☐ Severe Anxiety or Panic Attacks
☐ Other: _____

Respiratory (Lung) or ENT Disorders:
☐ Asthma
☐ COPD – Chronic Obstructive Pulmonary Disease
☐ Lung Cancer
☐ Pneumonia – Recurrent
☐ Sleep Apnea
☐ Tuberculosis (TB)
☐ Other: _____

Urinary Disorders:
☐ Calculus (Kidney Stone)
☐ Pyelonephritis
☐ Stress Incontinence
☐ Urge Incontinence / Overactive Bladder
☐ Urinary Tract Infections (UTI)
☐ Other: _____

Skin Conditions:
☐ Acne – Severe
☐ Eczema
☐ Hirsutism (excessive hair growth)
☐ MRSA
☐ Psoriasis
☐ Other: _____

Genetic Disorders:
☐ Cystic Fibrosis
☐ Muscular Dystrophy
☐ Other: _____

PAST SURGICAL HISTORY

Please include any D&C, D&E, Colposcopy, Cryotherapy or Colonoscopy Surgeries

Surgery	Reason for Surgery	Date of Surgery

MRN: _____
NAME: _____
DOB: _____
Two identifiers needed or Patient Label

CURRENT MEDICATIONS AND SUPPLEMENTS

Vitamins, Herbs and Supplements you are currently taking:

Product Name	Dose (if known)	How Often	Start Date	Reason

Medications, prescription and over the counter you are currently taking:

Drug Name	Dose (if known)	How Often	Start Date	Prescribed by

Primary Pharmacy: _____ Phone: _____

Pharmacy Address: _____

ALLERGIES

Do you have any known medication allergies? ☐ Yes ☐ No

Are you allergic to any of the following? (check all that apply)

☐ Contrast Dye ☐ Nickel ☐ Peanuts ☐ Latex ☐ Iodine ☐ Shellfish
☐ Adhesive Tape ☐ Band Aids
☐ Other: _____

Please list all allergies and the allergic reaction:

Allergic to: (medications, food, environmental)	Reaction

FAMILY MEDICAL HISTORY

If **ANY** close relative (brother, sister, parents, children, grandparents [maternal or paternal], Aunt or Uncle) has **ever had** or **currently has** any of the problems listed below, check and enter relationship to you.

Endometriosis	☐ Yes ☐ No	Who (be specific): _____
Uterine Fibroids	☐ Yes ☐ No	Who (be specific): _____
Breast Cancer	☐ Yes ☐ No	Who (be specific): _____
Colon Cancer	☐ Yes ☐ No	Who (be specific): _____
Heart Disease	☐ Yes ☐ No	Who (be specific): _____
High Blood Pressure	☐ Yes ☐ No	Who (be specific): _____
High Cholesterol	☐ Yes ☐ No	Who (be specific): _____
Blood Clots	☐ Yes ☐ No	Who (be specific): _____
Diabetes – Type I	☐ Yes ☐ No	Who (be specific): _____
Diabetes – Type II	☐ Yes ☐ No	Who (be specific): _____
Hyperthyroidism	☐ Yes ☐ No	Who (be specific): _____
Hypothyroidism	☐ Yes ☐ No	Who (be specific): _____
Lung Cancer	☐ Yes ☐ No	Who (be specific): _____
Bipolar Disorder	☐ Yes ☐ No	Who (be specific): _____
Ovarian Cancer	☐ Yes ☐ No	Who (be specific): _____
Uterine Cancer	☐ Yes ☐ No	Who (be specific): _____
Endometrial Cancer	☐ Yes ☐ No	Who (be specific): _____
Osteoporosis	☐ Yes ☐ No	Who (be specific): _____
Other Malignancies	☐ Yes ☐ No	Who (be specific): _____

Site of other malignancies: _____

MENSTRUAL HISTORY

*Period means # of days bleeding; cycle length means total # of bleeding and non-bleeding days until the next period begins.

Menopause Status: ☐ Premenopausal ☐ Postmenopausal ☐ perimenopausal

Are you Sexually Active? ☐ Yes ☐ No

With: ☐ Men ☐ Women ☐ Both

Age of first menstrual period: _____ Cycle Length: ☐ 28 days or _____

Number of days bleeding with a period: _____ Period Flow: ☐ Light ☐ Medium ☐Heavy

Date of last normal menstrual period (if abnormal describe): _____

_____

_____

Dartmouth Health

Alice Peck Day Memorial Hospital

New Patient Intake
Gynecology – Women's Care Center

MRN: _____

NAME: _____

DOB: _____

Two identifiers needed or Patient Label

PREGANCY HISTORY

Pregnancy Summary (How Many?)

Total # of Pregnancies	Full Term Births (more than 37 weeks)	Premature Births (less than 37 weeks)	Terminations	Miscarriages (was surgery needed?)	Ectopic Pregnancies (left or right)	Number of Living Children

please provide date of terminations, miscarriages and ectopic pregnancies

Comments: _____

_____

Pregnancy Details

Child's Birthdate (mm/dd/yr)	Child's Name	# Weeks at Delivery	Length of Labor (hours)	Birth Weight	Gender M or F	Type of Delivery Vaginal or C/S	Anesthesia Yes or No	Complications or Problems	Physician	Location

SOCIAL HISTORY

Marital Status: ☐ Dating ☐ Divorced ☐ Engaged ☐ Married ☐ Not Dating
☐ Separated ☐ Single ☐ Widowed ☐ Living with Significant Other

Alcohol Use: ☐ Never ☐ Current ☐ Former
How often: _____ Age Started: _____ Age Stopped: _____

Illegal Drug Use: ☐ Never ☐ Current ☐ Former
Which Drug: _____
Last Used: _____
How often: _____ Age Started: _____ Age Stopped: _____

Tobacco Use: ☐ Never ☐ Current ☐ Former
How often: _____ Age Started: _____ Age Stopped: _____

Caffeine Use: ☐ Yes ☐ No How Much: _____

Exercise Habits: ☐ Sedentary ☐ Active but no formal exercise
☐ Minimal Exercise (once weekly or less) ☐ Moderate Exercise (1-3 times weekly)
☐ Heavy Exercise (4 or more times weekly)
Type of Exercise: _____

Dartmouth Health — Alice Peck Day Memorial Hospital **New Patient Intake** **Gynecology – Women's Care Center**	MRN: _____ NAME: _____ DOB: _____ Two identifiers needed or Patient Label

Occupation: _____

Hobbies: _____

Check if you are currently having any of the following symptoms:

Constitutional:
☐ Weight Loss
☐ Weight Gain
☐ Fatigue/Weakness
☐ Fever

Eyes:
☐ Vision Problems

Head/Ears/Nose/Throat (HENT):
☐ Headaches

Breast:
☐ Breast lumps
☐ Breast pain
☐ Breast discharge
☐ Leaking milk

Cardiovascular:
☐ Chest pain
☐ Shortness of breath on exertion
☐ Heart murmur
☐ Swelling in legs

Respiratory:
☐ Wheezing
☐ Shortness of breath
☐ Spitting up blood
☐ Cough

Allergic-Immunologic:
☐ Sinus allergy symptoms

Genitourinary (genital and urinary):
☐ Not having periods
☐ Irregular periods
☐ Heavy periods
☐ Bleeding between periods
☐ Painful periods
☐ Pelvic pain
☐ Pain with intercourse
☐ Spotting with or after intercourse
☐ Decreased sex drive
☐ Vaginal discharge
☐ Vaginal dryness
☐ Hot flashes
☐ Urinary frequency
☐ Urinary urgency
☐ Difficulty starting to urinate
☐ Painful urination
☐ Blood in urine
☐ Leaking urine with cough
☐ Leaking urine with urge

Integumentary (skin):
☐ Rash
☐ Itching
☐ New skin lesions
☐ Changes in existing moles

Neurologic:
☐ Seizures
☐ Dizziness
☐ Syncope (fainting/passing out)

Check if you are currently having any of the following symptoms: *(continued)*

Gastrointestinal:
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Bloody stool

Endocrine:
☐ Excessive urination
☐ Excessive thirst
☐ Cold intolerance
☐ Heat intolerance
☐ Loss of hair
☐ Changes in hair texture
☐ Changes in skin texture
☐ Excessive hair growth

Musculoskeletal:
☐ Joint pain
☐ Joint swelling
☐ Muscle pain
☐ Muscular weakness

Psychiatric:
☐ Anxiety
☐ Depression
☐ Difficulty sleeping

Hematologic:
☐ Anemia
☐ Easy Bleeding
☐ Easy Bruising
☐ Swollen lymph nodes

WELL WOMAN SCREENING HISTORY

Please indicate the date of your last:

Diagnostic tests:

Pap: _____ ☐ Never

Mammogram: _____ ☐ Never

Colonoscopy: _____ ☐ Never

Dexa (Bone) Scan: _____ ☐ Never

Lab work:

Lipid Screening: _____

Glucose Test: _____

PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH HEALTH

Use this form when you want your records sent to Dartmouth Health from another provider/facility.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Ph: _____

Address: _____

City: _____ State: _____ Zip: _____

SENDER

I authorize:

Name of Provider/Facility: _____

_____

Address: _____ City: _____

State: _____ Zip: _____ Fax: (_____) _____

RECIPIENT:

To share (disclose) my health information with Dartmouth Health, please send my records to the following Dartmouth Health member location:

❑ **Alice Peck Day** Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 650-7110 Fax: (603) 640-1970 Email: medicalrecords@apdmh.org	❑ **Cheshire Medical Center** HIM Department 590 Court Street Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 676-4253 Email: cmcroi@cheshire-med.com	❑ **Dartmouth Hitchcock Medical Center** Health Information Services 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7406 Email: Lebanon.Release.of.Information@hitchcock.org	❑ **Hanover Psychiatry** 23 S. Main St., Suite 2B Hanover, NH 03755 Ph: (603) 277-9110 Fax: (603) 277-9154
❑ **Manchester, Nashua & Concord - DH** Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 727-7828 Email: DH-ROI@hitchcock.org	❑ **New London Hospital** Health Information Services 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051 Email: NLHMedicalRecords@NewLondonHospital.org	❑ **Newport Health Center** Release of Information 11 John Stark Highway Newport, NH 03773 Ph: (603) 865-2855 Fax: (603) 863-3585	❑ **Visiting Nurse and Hospice for VT/NH** Health Information Services 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7406 Email: Lebanon.Release.of.Information@ hitchcock.org

If mailing my information, please return requested records to the following department/section or provider:

_____

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

- ❑ Discharge Summary
- ❑ Inpatient Progress Notes
- ❑ Outpatient Visit (Office) Notes
- ❑ Other: _____
- ❑ Emergency Department Reports
- ❑ Laboratory/Pathology Reports
- ❑ School Physical Forms
- ❑ Records from a Specific Provider: _____
- ❑ Immunizations
- ❑ Operative Reports
- ❑ X-Ray Reports
- ❑ X-Ray Films

For the following purpose: _____

SENSITIVITE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Dartmouth Health to include the location noted above UNLESS I place my initials in the applicable space below, next to the type of records:**

- _____ Mental health treatment records
- _____ Genetic testing
- _____ HIV/AIDS test results
- _____ Sexually transmitted disease (STD) treatment records
- _____ Alcohol/drug abuse treatment records

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: _____ (date). I or my Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: Dartmouth Health and _____ **[SENDER NAME]** will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. My sending healthcare provider may require fees to process my request.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Description of Personal Representative's Authority