**MEXICO WOMENS HEALTH SPECIALISTS**
**626 SUMMIT, SUITE J MEXICO, MO 65265**
**(Phone)573-581-7040 – (Fax)573-581-3302**

**Michael D. Jones, M.D.F.A.C.O.G.** **Carla Price, F.N.P.-B.C.**

NAME:_____ MARITAL STATUS: M S W D
Last First Middle (Circle One) Separated

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____ SS#_____ TELEPHONE_____

EMAIL ADDRESS:_____ CELL# _____

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ EMPLOYER'S TELEPHONE_____

HUSBAND'S NAME_____ DATE OF BIRTH_____ SS#_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ EMPLOYER'S TELEPHONE_____

NEAREST FRIEND OR RELATIVE **NOT** RESIDING WITH YOU_____

RELATIONSHIP_____ TELEPHONE(HOME)_____ (WORK)_____

(CELL)_____

MEDICATION ALLERGIES_____

REFERRED BY DR:_____ PRIMARY DR_____

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

SUBSCRIBER_____ SUBSCRIBER_____

POLICY #_____ POLICY#_____

GROUP#_____ GROUP#_____

**SIGNATURE ON FILE:**
I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES. I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS. I AUTHORIZE MY PHYSICIAN TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL FOR ANY AND ALL SERVICES. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO REFERRING PHYSICIANS CONCERNING MY ILLINESS AND TREATMENTS.

**SHOULD THIS ACCOUNT BECOME DELINQUENT THE UNDERSIGNED AGREES TO PAY ALL OF COLLECTOR'S COLLECTION EXPENSES, INCLUDING ALL COLLECTION AGENCY FEES AND ALL ATTORNEY FEES. IF SUIT IS BROUGHT, IT MAY BE FILLED IN THE COUNTY WHERE SERVICES WERE RENDERED.**

SIGNATURE_____ DATE_____

(PRINT NAME)_____

**FAMILY HISTORY** – **Michael D. Jones, M.D. F.A.C.O.G. - Carla Price, FNP**
**626 Summit, Suite J, Mexico, MO 65265**

**HAS ANYONE IN YOUR IMMEDIATE FAMILY EVER BEEN TREATED FOR ANY OF THE FOLLOWING?**
**(GRANDPARENTS, PARENTS, SIBLINGS)**

DIABETES_____ HYPERTENSION (High Blood Pressure)_____

STROKE_____ CORONARY ARTERY DISEASE (HEART ATTACK, BYPASS SURGERY, ANGIOPLASTY)_____

HAVE YOU EVER HAD SURGERY? YES_____ NO_____

**PLEASE LIST SURGERY AND LIST THE YEAR OF SURGERY**

TONSILLECTOMY_____ APPENDECTOMY_____

D&C_____ GALLBLADDER_____

MASTECTOMY_____ HYSTERECTOMY_____

WERE YOUR OVARIES REMOVED? BOTH_____ RIGHT_____ LEFT_____

ANY OTHER SURGERY?_____

ANY OTHER HOSPITALIZATIONS? _____

**ARE YOU TAKING ANY MEDICATION? PLEASE LIST MEDICATIONS AND DOSAGE.**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? YES_____ NO_____

PLEAE LIST MEDICATION AND TYPE OF REACTION

**MEDICATION**_____ **REACTION**_____

_____ _____

_____ _____

DO YOU SMOKE? YES_____ NO_____ HOW MANY PACKS PER DAY_____
DO YOU DRINK? YES_____ NO_____ HOW MANY PER DAY_____ WEEK_____

DO YOU HAVE ANY PROBLEMS WITH BLADDER CONTROL? YES_____ NO_____

**IF YOU HAVE ANY PROBLEMS WITH LEAKING URINE WHEN COUGHING, EXERCISING, ETC., PLEASE MENTION THIS TO THE NURSE BEFORE YOU USE THE RESTROOM.**

WERE YOU REFERRED BY ANOTHER DOCTOR? DR._____
PRIMARY DR_____

**DO NOT WRITE BELOW THIS LINE**

WEIGHT_____ BP_____ LMP_____ G_____ P_____ AB_____

TETANUS_____ FLU VACCINE_____ PNEUMONIA VACCINE_____ TSH_____

**MEDICAL HISTORY QUESTIONNAIRE:** **Michael D. Jones, M.D.,F.A.C.O.G. - Carla Price, FNP**
**626 Summit, Suite J, Mexico, MO 65265**

**ALL INFORMATION IS STRICTLY CONFIDENTIAL. IF THERE IS ANY INFORMATION YOU WOULD PREFER TO DISCUSS WITH THE NURSE OR DOCTOR DIRECTLY, PLEASE FEEL FREE TO DO SO.**

NAME_____AGE_____DATE_____

REASON FOR VISIT_____

DATE OF LAST PAP SMEAR_____WHERE_____

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?_____

DATE OF LAST MAMMOGRAM_____WHERE_____

FIRST DAY OF YOUR LAST MENSTRUAL PERIOD_____AGE AT FIRST PERIOD_____

HOW FREQUENT ARE YOUR PERIODS?_____IRREGULAR_____

DO YOU CONSIDER YOUR PERIODS HEAVY_____NORMAL_____LIGHT_____

HOW MAY PADS/TAMPONS PER DAY?_____

DO YOU HAVE MENSTRUAL CRAMPS? SEVERE_____MODERATE_____MILD_____

DO YOU HAVE PAIN WITH INTERCOURSE? YES_____NO_____

**CONTRACEPTIVE CURRENTLY USED – FOR SEXUALLY ACTIVE PATIENTS**

PILL_____IUD_____DEPOPROVERA_____CONDOMS_____

FOAM_____WITHDRAWAL_____RHYTHM_____TUBAL LIGATION_____

VASECTOMY_____NONE_____

TOTAL PREGNANCIES_____ANY PREMATURE DELIVERIES_____

MISCARRIAGES_____ANY COMPLICATIONS_____

**HAVE YOU EVER BEEN TREATED FOR:**

RHEUMATIC FEVER_____EPILEPSY_____BLOOD CLOT IN LEGS/LUNGS_____

DIABETES_____DEPRESSION_____ASTHMA_____ANEMIA_____

VARICOSE VEINS_____HYPERTENSION (High Blood Pressure)_____MIGRAINE HEADACHE_____
(NOT SPIDER VEINS)

LIVER DISEASE_____KIDNEY DISEASE_____THYROID CONDITION_____

CORONARY ARTERY DISEASE_____(HEART ATTACK, BYPASS, ANGIOPLASTY)

ANY OTHER SERIOUS ILLNESS_____

**HAS ANYONE IN YOUR FAMILY EVER BEEN TREATED FOR CANCER OF THE:**

BREAST_____OVARIES_____

UTERUS_____COLON_____