Advocate Health Care, PLLC

Renée Woods, MD

Patient Registration

Today's Date: ____________________

Name ____ Date of Birth: ____________

Address: ____

City: ____________________________ State: _______ Zip: __________________

Cell Phone: ______________________ Home Phone: _______________________

Email Address: ____

Preferred Pharmacy: ____

Primary Care Physician: ____

Emergency Contact Information:

Name: ______________________________________ Relationship: ___________

Phone Number(s): ____

Form may be submitted in person to:

Advocate Healthcare, PLLC
Renée Woods, MD
4702 Summitview Ave Suite 102
Yakima, WA 98908

Advocate Health Care, PLLC

Renée Woods, MD

Consent to Treatment

I voluntarily consent to medical treatment and diagnostic procedures provided by Advocate Health Care and its associated physicians, clinicians, and other personnel.

I consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis, and testing for drugs if deemed advisable by my physician.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as the result of treatments or examinations.

Name: ____

Signature: ____ Date: _______________

Acknowledgement of Foundational Lab Review Policy & Appointment Cancellation

I have agreed to schedule and pay for a Foundational Assessment medical appointment with Dr. Woods through Advocate Health Care, and understand that the results of any blood tests and lab work performed prior to that appointment will NOT be shared with me prior to that appointment.

I understand that if I request lab results to be delivered or shared with me in person prior to the Foundational Assessment with Dr. Woods, I will be subject to termination as a patient and member from Advocate Health Care and Dr. Woods practice for no less than 12 months and will be charged a cancellation fee of $350.

I also understand that if I cancel a scheduled appointment after lab work has been performed, I will owe a cancellation fee of $350.

Signature: ____ Date: _______________

Thank you for completing this form at each visit.

Name: **DOB:** **Date:**

Please provide updated information if there have been any changes since your last visit.			
Street Address:			
City, State, Zip:			
Home Phone:		Work Phone:	
Marital Status:		Spouse/Partner Name:	
Occupation:		Education:	
Insurance:			

What brings you to the office today?			
☐	Annual Exam or Routine Care	☐	New Patient Visit
☐	Pelvic Floor Rehabilitation	☐	Review Lab Results
☐	Problem/Concern/Other (Please describe briefly):		

Gynecologic History			
Date of Last Menstrual Period:		Every ______ Days	Lasting ______ Days
Date of Last Pap Smear:		Normal Results?	☐ Yes ☐ No
Date of Last Mammogram:		Normal Results?	☐ Yes ☐ No
Current Method of Contraception:			

Please describe any changes to your medications and medication allergies since your last visit.	
Medication Update:	
Allergy Update:	

Please inform us of any changes to your family history since your last visit.					
☐ Diabetes	☐ Stroke	☐ Heart Disease	☐ High Blood Pressure	☐ Cancer: Breast, Ovarian, Colon	☐ Drinking Problem

Please mark any symptoms you are having today:

General
- ☐ Weight Loss or Gain
- ☐ Fevers
- ☐ Trouble Sleeping
- ☐ Chronic Fatigue
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Abnormal Thirst

Eyes
- ☐ Itchy, Red Eyes
- ☐ Vision Problems

Ears
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Hearing Loss

Nose
- ☐ Sinus Problems
- ☐ Nose Bleeds

Mouth
- ☐ Sore Throat
- ☐ Mouth Sores

Lungs
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Blood Clot in the Lungs
- ☐ Painful Breathing
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Burn
- ☐ Ankle/Hand Swelling

Gastrointestinal
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids

Urinary
- ☐ Incomplete Urination
- ☐ Loss of Urine
- ☐ Painful Urination
- ☐ Bloody Urine

Musculoskeletal
- ☐ Muscle Weakness
- ☐ Joint Pains
- ☐ Joint Swelling
- ☐ Clot in Leg Vein

Neurological
- ☐ Frequent/Severe Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble Walking
- ☐ Fainting Spells

Skin
- ☐ Acne
- ☐ Dry Skin
- ☐ Unwanted Hair Growth
- ☐ Unusual Lump or Growth

Emotional
- ☐ Excessive Worry
- ☐ Depression
- ☐ Frequent Crying
- ☐ Serious Thoughts of Harming Yourself or Others

Menstrual Problems
- ☐ Cramps/Pain
- ☐ Heavy Bleeding
- ☐ Too Frequent Periods
- ☐ Bleeding Between Periods
- ☐ Missed a Period
- ☐ Other Period Issue

Pre Menstrual Issues
- ☐ Bloating, Swelling
- ☐ Mood Changes
- ☐ Breast Changes
- ☐ Headaches
- ☐ Acne
- ☐ Other PMS Issue

Menopause Issues
- ☐ Hot Flashes
- ☐ Night Sweats

Breast Problems
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Other Breast Issue

Other Gynecological Issues
- ☐ Vaginal Discharge
- ☐ Itching, Irritation
- ☐ Vulvar Pain
- ☐ Vulvar Lump, Growth
- ☐ Vulvar Sores

Sexual Problems
- ☐ Painful Intercourse
- ☐ Bleeding After Intercourse
- ☐ Decreased Desire
- ☐ Orgasm Problems
- ☐ Dryness
- ☐ Possible Exposure to STD
- ☐ Other Sexual Issue

Would you like to discuss any of the following?
- ☐ Contraception
- ☐ Menopause Issues
- ☐ Pregnancy Issues
- ☐ Self Breast Exam
- ☐ Sexuality Issues
- ☐ STD's
- ☐ Other

Signature: ______________________________

Revised 12/22/2016

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name ________________________ **Date** ______________

Provider ________________________ **Patient ID #** ______________

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ______

Somewhat difficult ______

Very difficult ______

Extremely difficult ______

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

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