



Dear New Patient:

Thank you for selecting Meridian Women's Health as your medical provider. In order to provide the very best and most efficient care please complete the enclosed forms describing your health status and concerns. This will save you time and help us make your visit much more productive.

Please read all of the information enclosed in this new patient packet. It is essential that you bring all of the following items:

1. Picture Identification (i.e. drivers license)
2. Insurance card and co-pay (if applies)
3. Completed Patient Registration form (enclosed)
4. Completed Health Questionnaire (enclosed)

If you misplace the forms listed above they can be found on our website [www.meridianwomenshealth.com](http://www.meridianwomenshealth.com). Valuable information, as well as our clinic policies can also be found on this website.

Due to the large volume of patients in our practice we require at least 24-hour notification of a cancellation. This enables us to offer your appointment time to another patient. Our office is available to take cancellation calls from 8:00am to 4:00pm Monday, Tuesday, Wednesday, Thursday and Friday 8:00am-12:00pm. Please note that calls made to the answering service after hours will be considered less than a 24-hour notification.

For our patient's convenience, we collect all lab specimens in our office and they are sent to an outside laboratory. Your services will be billed directly from Northwest Clinical Labs or Cellnetix. If you have any questions regarding this policy please let the office know prior to your appointment.

Your health is our most important concern. If we have the most complete and accurate information we can provide the finest care and service to you. Thank you for your preparation, we look forward to meeting you in the near future.

Sincerely,

Dawn Frankwick, MD

Patricia Rodrigues, MD

Carol Salerno, MD

Danae Vu, MD

**MERIDIAN WOMEN'S HEALTH**  
**10330 Meridian Avenue N. #200**  
**Seattle, WA 98133**  
**(206) 368-6644**

**PLEASE COMPLETE ALL SECTIONS - IN BLUE OR BLACK INK**

<b>PATIENT NAME:</b>			<b>DATE:</b>		
<b>Last:</b>	<b>First:</b>	<b>MI:</b>			
NAME YOU LIKE TO BE CALLED:					
MAIDEN NAME:					
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced					
Address:		Apt#:	City:	State:	Zip:
Home Phone:(    )			Cell Phone: (    )		
Social Security #:			Text Message Reminders    Yes <input type="checkbox"/> No <input type="checkbox"/>		
Birthdate:		Age:	Primary Care Physician:		
Employer:					
Work Phone:(    )					
Responsible Billing Party/Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Partner/Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent					
<i>(give address and phone if different than above)</i>					
Spouse or Partner's Name/Parent's Name (if patient is a minor):					
Spouse, Partner or Parent's Phone: (    )					
Whom shall we call in an emergency?    (Please give name, address, area code and phone number of someone not living with you)					
<i>Relationship to You:</i>					
<b>Reason for visit:</b>					

<b>Primary</b> Medical Insurance Carrier:		Member #:
Subscriber Name & DOB:		Group #:
Medicare Number:		
<b>Secondary</b> or Medicare Supplement Insurance Carrier:		Member #:
Subscriber Name & DOB:		Group #:
<b>I have no insurance. I agree to pay today for services provided to me by Meridian Women's Health.</b>		
<b>SIGNATURE:</b>		Date:
<b>Assignment and Release:</b> I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I also authorize the doctor or insurance company to release any information required for this claim.		
<b>SIGNATURE:</b>		Date:
<b>I acknowledge receipt of Northwest Hospital &amp; Medical Center's Notice of Privacy Practices.</b>		
<b>SIGNATURE:</b>		Date:
<i>How did you hear about Meridian Women's Health?</i>		
Referred by Dr. _____		Other: _____



**Authorization to Leave Personal Health Information  
By Alternate Means**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

**(Please check all that apply)**

- May leave detailed message on voicemail at **home #**: \_\_\_\_\_
- May leave detailed message on voicemail at **work #**: \_\_\_\_\_
- May leave information with **spouse (name) and #**: \_\_\_\_\_
- May leave information with other **family member (name) and #**: \_\_\_\_\_
- May leave detailed message on **cellular phone #**: \_\_\_\_\_
- May send **automated text messages** for appointment reminders/schedule changes
- May leave detailed message at a **different phone #**: \_\_\_\_\_

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

Health Care for Women by Women  
10330 Meridian Ave N. Ste 200 Seattle, WA 98133 *phone 206-368-6644 fax 206-368-6645*

# MERIDIAN WOMEN'S HEALTH

## NEW PATIENT HEALTH QUESTIONNAIRE

Name \_\_\_\_\_

(please print)

Date \_\_\_\_\_ Age: \_\_\_\_\_

Problems to discuss today \_\_\_\_\_

### MEDICAL HISTORY

#### Circle any past medical problems:

High blood pressure	Diabetes	Heart murmur	Angina	Heart attack
Tuberculosis	Asthma	Pneumonia	Bronchitis	Thyroid disease
Sickle cell trait	Anemia	Glaucoma	Cancer	Osteoporosis
Kidney infections	Depression	Headache	Arthritis	Seizures
Indigestion	Hepatitis	Diverticulosis	Ulcers	

Any other significant medical problems: \_\_\_\_\_

Previous surgeries (include dates) \_\_\_\_\_

Current Medications/Vitamins/Over the counter meds or herbs \_\_\_\_\_

Allergies to medications \_\_\_\_\_

Date of last cholesterol screening \_\_\_\_\_ Date of last sigmoidoscopy / colonoscopy \_\_\_\_\_

History of blood transfusion? \_\_\_\_\_

### GYNECOLOGICAL HISTORY

# of pregnancies \_\_\_\_\_ # of children \_\_\_\_\_

First day of last period \_\_\_\_\_ Period occurs every \_\_\_\_\_ days Regular? \_\_\_\_\_ Period lasts \_\_\_\_\_ days

Age at 1st period \_\_\_\_\_ Age at menopause \_\_\_\_\_ Date of last pap smear \_\_\_\_\_

Method of birth control currently used \_\_\_\_\_ Date of last mammogram \_\_\_\_\_

If menopausal, are you on hormone replacement? \_\_\_\_\_ Hormones used \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ New sexual partner? \_\_\_\_\_

Do you wish to be checked for sexually transmitted diseases? \_\_\_\_\_ Do you feel safe at home? \_\_\_\_\_

**Circle GYN problems you have had in the past:**

Endometriosis	Infertility	Fibroids	Genital warts
Gonorrhea	Chlamydia	Breast problems	Herpes
Ovarian cysts	Abnormal Pap	Pelvic Inflammatory Disease	

### PATIENT SOCIAL HISTORY

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Partner \_\_\_\_\_

Current Occupation \_\_\_\_\_

Spouse (name, age, medical problems) \_\_\_\_\_

Children (names, ages, medical problems) \_\_\_\_\_

Use of Alcohol: Drinks/week \_\_\_\_\_ Quit when \_\_\_\_\_ Have you ever felt the need to cut down? \_\_\_\_\_

Use of Caffeine, Cups per Day: Coffee \_\_\_\_\_ Soda \_\_\_\_\_ Tea \_\_\_\_\_

Use of Tobacco: Never \_\_\_\_\_ Previously, but quit \_\_\_\_\_ Current Packs/Day \_\_\_\_\_

Use of Drugs: Never \_\_\_\_\_ Previously, but quit \_\_\_\_\_ Type / Frequency \_\_\_\_\_

Exercise: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Weekly \_\_\_\_\_ Daily \_\_\_\_\_ Type of Exercise \_\_\_\_\_

### FAMILY MEDICAL HISTORY: Do you know of any blood relative who has or had: (indicate relationship)

Breast Cancer \_\_\_\_\_ Bleeding Tendency \_\_\_\_\_

Ovarian Cancer \_\_\_\_\_ Heart Disease \_\_\_\_\_

Colon Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Diabetes \_\_\_\_\_ Mental Illness \_\_\_\_\_

Osteoporosis \_\_\_\_\_ TB \_\_\_\_\_

**ADDITIONAL QUESTIONS ON BACK OF FORM**

NAME \_\_\_\_\_

**ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:**

**CONSTITUTIONAL SYMPTOMS**

- Unexplained weight gain or loss ..... yes no
- Fever or chills ..... yes no
- Night sweats/Hot flashes ..... yes no
- Fatigue ..... yes no

**HEMATOLOGIC/LYMPHATIC**

- Bleeding or bruising tendency ..... yes no
- Anemia ..... yes no

**EYES**

- Blurred or double vision ..... yes no

**EARS/NOSE/MOUTH/THROAT**

- Chronic sinus problem or rhinitis ..... yes no
- Hay fever ..... yes no

**CARDIOVASCULAR**

- Chest pain or angina ..... yes no
- Irregular heart rate ..... yes no
- High blood pressure ..... yes no

**RESPIRATORY**

- Shortness of breath ..... yes no
- Asthma or wheezing ..... yes no

**GASTROINTESTINAL**

- Loss of appetite ..... yes no
- Change in bowel movements ..... yes no
- Nausea or vomiting ..... yes no
- Frequent diarrhea ..... yes no
- Painful bowel movements or constipation ..... yes no
- Rectal bleeding or blood in stool ..... yes no
- Abdominal pain ..... yes no

**GENITOURINARY**

- Frequent urination ..... yes no
- Painful urination ..... yes no
- Blood in urine ..... yes no
- Urination at night (> 1/night)? ..... yes no
- Urinary incontinence ..... yes no
- Sexual difficulty ..... yes no
- Infertility ..... yes no
- Pain with periods ..... yes no
- Irregular periods ..... yes no

**MUSCULOSKELETAL**

- Joint pain ..... yes no
- Back pain ..... yes no

**INTEGUMENTARY (skin, breast)**

- Rash or itching ..... yes no
- Breast pain ..... yes no
- Breast lump ..... yes no
- Breast discharge ..... yes no

**NEUROLOGICAL**

- Frequent or recurring headaches ..... yes no
- Light headed or dizzy ..... yes no
- Convulsions or seizures ..... yes no
- Numbness or tingling sensations ..... yes no

**OTHER**

- Nervousness ..... yes no
- Depression/Anxiety/Panic ..... yes no
- Insomnia ..... yes no
- Current emotional or physical abuse ..... yes no

Other concerns:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Initials: \_\_\_\_\_

Date: \_\_\_\_\_