Patient Information

Patient Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Birth Date:_____ Age:_____

Marital Status: M S W D Do you identify as: Male Female Other_____

Primary language: English Spanish Other:_____Email Address: _____

Can we leave a detailed message on your voicemail/answering machine regarding results from your visit: YES NO

IF YOU ANSWERED **NO**, HOW WOULD YOU LIKE US TO CONTACT YOU:_____

Referred By: _____

AIDIN WELLNESS FINANCIAL POLICY

June Franzen, Nurse Practitioner, appreciates the confidence you have shown in choosing her to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment IN FULL of our fees the day of service. I agree to pay Aidin Wellness/June Franzen, the full and entire amount due the day of service.

- Payment for **ALL** services are **due at the time of your appointment**. We accept cash, credit/debit/HSA card payments
- There is a ***5% discount for paying for your appointment with cash***. Use of credit/debit/HSA card will **not** qualify for the discount.
- Initial patient visit is $79 for in-person or telehealth appointment.

You are responsible for the cost of all labs, medications, and treatment/services. If you have insurance coverage, your labs/tests may be covered, that is totally dependent on your personal agreement with your insurance company. I understand and take full responsibility for any amounts not covered by my insurance provider. Refunds or credits are not permitted on any medications or treatments received. If payment is made with non-sufficient funds (NSF) a $40.00 fee will be added above and beyond the original charge.

Consent for treatment:

I authorize June Franzen, APRN to provide medical services today and for all future appointments. I understand I am financially responsible for all of the charges. This consent will stay in effect until I discontinue receiving health care at Aidin Wellness.

Patient/guardian/parent: (Print)_____ Date: _____

Patient/guardian/parent: (Signature)_____

Reason for Today's Visit:

_____

When did you fist notice the symptoms:

_____

What treatment have you received?

_____

Name of other Dr that have treated you:

_____

Exercise on a weekly basis? None Mild(1-2 days) Moderate(3-4 days) Heavy(5-7 days)

Do you Smoke? No Yes How many daily____ Age started____ Former smoker____

Marijuana/other drugs? No Yes How many daily____ Age started____ Former user_____

Do you Drink Alcohol? No Yes Number of drinks per week? _____

Has anyone ever told you to cut down on your drinking or are you concerned about your drinking? Yes No

Do you use drugs for reasons that are not medical? Yes No

Surgical History:

Have you had a Hysterectomy? Yes No If Yes, Why?_____

Surgery	Date	Reason

Family History:

Mother: Alive Deceased Age:_____ Medical History:_____
Father: Alive Deceased Age:_____ Medical History:_____
Sisters: Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____
Brothers: Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____
Daughters: Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____
Sons: Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____
Alive Deceased Age:_____ Medical History:_____

Medications:

Allergies:_____ Reaction:_____

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Allergies:_____ Reaction:_____

Pharmacy:_____ Location (City):_____

Current Hormone Replacement Therapy? Yes No

If **YES** list current medications, doses and type of medication (pills, creams, pellets, etc**.)_____**

_____

Medication (name on the bottle)	Dose (mg)	How many pills daily	Refill Needed?

Do **YOU** have a personal history of the following?
(X) Check all that apply.

PREVENTITVE MEDICAL CARE:

Women:

( ) Medical/Physical exam in the last year
( ) **Mammogram** in the last 12 months
Was it normal ( ) YES ( ) NO
( ) Pelvic exam/Pap in the last 12 months
( ) Bone Density (DEXA) in the last 12 months
( ) Pelvic Ultrasound in the last 12 months
( ) Colonoscopy – date _____

Men:

( ) Medical/Physical exam in the last year
( ) Prostate exam and/or PSA test in the last 12 months
Was it normal ( ) YES ( ) NO
( ) Colonoscopy – date _____

HIGH RISK PAST MEDICAL/SURGICAL HISTORY:

( ) **Breast Cancer**
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Oophorectomy (removal of ovaries)
( ) **Prostate Cancer**
( ) **Elevated PSA**

BIRTH CONTROL METHODS:

( ) **Menopause**
( ) **Hysterectomy**
( ) Tubal Ligation
( ) **Birth Control:**
( ) Pills ( ) IUD ( ) Patch ( ) Implant
( ) Shot ( ) Condoms
( ) Vasectomy
( ) Other: _____

GENERAL MEDICAL HISTORY:

( ) Fatigue
( ) Weight loss or Weight gain
( ) **Headache/Migraine**
( ) Asthma
( ) Shortness of Breath/Chest Pain
( ) High Blood Pressure
( ) Palpitations
( ) History of Heart attack
( ) Heart Stents/surgery/bypass
( ) Stroke
( ) **Joint Pain/Muscle Pain**
( ) Anxiety
( ) **Memory Loss**
( ) Schizophrenia/Bipolar
( ) Depression
( ) **Mood Changes**
( ) Excessive Stress
( ) Breast Pain/tenderness/Discharge/Lumps
( ) Abdominal pain
( ) Gallbladder Disease
( ) Hepatitis/fatty liver/cirrhosis
( ) Constipation
( ) Bleeding easily
( ) Blood clots/Bleeding Disorders
( ) Cold/heat intolerance
( ) Diabetes
( ) **Thyroid trouble**
( ) Awakening to Urinate
( ) Blood in Urine
( ) Cystocele/bladder 'falling'
( ) Difficulty starting Stream or emptying bladder
( ) Excessive Urination
( ) Flank pain/kidney stone
( ) Urinary Frequency
( ) Incontinence – bowel or bladder
( ) Painful urination
( ) Erectile dysfunction/painful erection
( ) Decreased sexual desire
( ) Pain with intercourse
( ) Abnormal pap – history
( ) Abnormal Vaginal Discharge
( ) Vulvar/vaginal Itching/Lesion/bumps
( ) Infertility/PCOS
( ) Sexually transmitted infections – history or current symptoms
( ) Bleeding after Menopause
( ) Changes in period
( ) Painful periods
( ) Heavy bleeding
( ) Vaginal Dryness
( ) Sexual Problems _____
Date of Last Period_____

Have you ever been pregnant **YES NO**
How many times _____
How many miscarriages/abortions_____
How many live births _____

Other Health Problems:_____

_____

_____

Other questions/concerns:_____

_____

_____