Women First Specialists S.C

	Main Office	Stone Medical Center	South Office
Raynelda Hidalgo, MD FACOG	6121 N. Elston Ave.	2845 N. Sheridan Rd. suite #712	10510 S. Roberts Rd.
Ewa Bilinski, MD FACOG	Chicago, IL, 60646	Chicago, IL, 60657	Palos Hills, IL, 60465
Emily Lombard, DO FACOG	Tel. (773)792-0209	Tel. (773)525-0000	Tel. (708)974-5025
Vanessa Archil, MD FACOG	Fax. (773)792-0112	Fax. (773)525-0061	Fax. (708)974-5028

Date _____ Referred by _____

Last Name _____ **First Name** _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone Number (___) _____ Cell Phone Number (___) _____

Occupation _____ E-mail address _____

Employer Phone Number (___) _____

Social Security Number ___ - ___ - ___ Date of Birth ___ / ___ / ___

Marital Status: ◇ Divorced ◇ Separated ◇ Married ◇ Single ◇ Widowed

Primary Insurance Name _____ ◇ HMO ◇ PPO ◇ POS

Identification Number _____ Group Number _____

Copayment _____ Deductible _____

Insured Last & First Name _____ Insured Date of Birth _____

Insured Address _____

City _____ State _____ Zip Code _____

Secondary Insurance Name _____ HMO PPO POS

Identification Number _____ Group Number _____

Copayment _____ Deductible _____

Insured Last & First Name _____ Insured Date of Birth _____

Insured Address _____

City _____ State _____ Zip Code _____

Emergency Phone Number _____ Name/Relation _____

Authorizations:

I authorize the release of any information, including diagnosis and treatment rendered to me, to process insurance claims in my behalf. I authorize and request payment of medical insurance benefits to be sent directly to Dr. Raynelda Hidalgo, Dr. Ewa Bilinski, Dr. Emily Lombard, Dr. Vanessa Archil. I also understand I am financially responsible for any and all services which are not covered by my insurance company.

Signature of Patient _____

Date: _____

Personal Medical History (PLEASE COMPLETE BOTH PAGES)

First and Last Name:_____

Birth Date: _____

PCP: _____PCP OFFICE PHONE # _____

Preferred Pharmacy: _____Pharmacy Address: _____

MEDICAL HISTORY: (please mark all past or present conditions and/or symptoms)

Anemia_____, Easy bruising_____, Chest pain_____, Shortness of breath_____, Diarrhea_____,

Constipation_____, Blood in stool_____, Abdominal pain_____, Pelvic pain_____, Bloating_____,

Nausea/Vomiting_____, Urinary Incontinence_____, Stool Incontinence_____,

Urinary problems _____, Vaginal problems_____, Heavy periods_____, Painful periods_____,
Thyroid disease_____, Diabetes_____, High blood pressure_____, Hearing loss_____,

Vision loss_____, Seizure_____, Cancer_____, Depression_____, Anxiety_____,

Bipolar disorder_____, Asthma_____, Uterine fibroids_____, Endometriosis_____,

Renal disease_____, Liver disease_____, Migraines_____,

History of STI (sexually transmitted infections)
HIV_____, Syphilis_____, Chlamydia_____, Gonorrhea_____, Hepatitis_____, HPV_____,
Trichomonas_____,

OTHER:_____
_____

CURRENT MEDICATIONS:

Medication	**Dose**	**How often**

ALLERGIES

_____

_____

SURGICAL HISTORY (what kind of surgery and when)

_____

_____

SOCIAL HISTORY:

Do you smoke? _____ How much per day?_____

Do you drink? _____How much per week?_____

Do you use illicit drugs or regular prescription pain medications? _____What kind?_____

What is your occupation?_____

Do you use special diets?_____

How many times per week do you walk or exercise? _____Do you use seatbelts?_____

PREGNANCIES:

Number_____, Living children_____, Miscarriages_____, Abortions_____,

Ectopic pregnancies _____.

SIGNIFICANT FAMILY HISTORY

	Alive	**Medical Problems**
Father:		
Mother:		
Brother(s):		
Sister(s):		
Other (grandparents, aunts, uncles):		

HEALTH SCREENING HISTORY (please specify *when* you had the test done and its *results*)

- **Last Pap smear** _____
- **Last Mammogram** _____
- **Colonoscopy** _____
- **Gardasil vaccination** _____
- **DXA screen** _____

***Dr.* _____ *has reviewed this form on* _____**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have read the Notice of Privacy Practices

Signature _____

Print Name _____

Date _____

OFFICE USE ONLY

Unable to obtain patient's written acknowledgement because:

- ◇ **Patient refused to sign**
- ◇ **Patient is incapacitated and no responsible party is available prior to discharge**
- ◇ **Other** _____

_____

insight
MEDICAL GENETICS

CANCER RISK ASSESSMENT INTAKE FORM

PATIENT NAME _____

DATE OF BIRTH _____

Please check all boxes that apply:

	PERSONAL	RELATIVE (include relationship)	N/A
1. Breast Cancer at age ≤50	☐	☐ _____	☐
2. "Triple Negative" Breast Cancer (Estrogen Receptor (ER) negative, Progesterone Receptor (PR) negative, HER2neu negative)	☐	☐ _____	☐
3. Ovarian, fallopian tube, or primary peritoneal cancer	☐	☐ _____	☐
4. Male breast cancer	☐	☐ _____	☐
5. Bilateral breast cancer (cancer in both breasts) or two breast primaries (1 dx'd <50 yrs)	☐	☐ _____	☐
6. Ashkenazi (Eastern/Central European) Jewish ancestry with breast or ovarian cancer	☐	☐ _____	☐
7. Pancreatic or Prostate Cancer (High grade/ Gleason score ≥7) with a family history of breast or ovarian cancer	☐	☐ _____	☐
8. Colorectal cancer or several pre-cancerous polyps (adenomas) at an age ≤50	☐	☐ _____	☐
9. Endometrial (uterine) cancer at age ≤50	☐	☐ _____	☐
10. 10 or more total pre-cancerous polyps (adenomas) in a person's lifetime	☐	☐ _____	☐
11. Two or more cases of the same type of cancer on one side of the family (ex. breast, ovarian, colon, kidney, sarcoma, thyroid, melanoma)	☐	☐ _____	☐
12. History of multiple primary cancers	☐	☐ _____	☐
13. Personal and/or family history of a known genetic mutation	☐	☐ _____	☐