2695 Ulmerton Rd.
Clearwater, FL 33762
Phone: (727) 540-0414
Fax: (727) 540-0672

Visionary
Centre for Women

JENNIFER S. HAYES DO, FACOOG

Today's Date: _____

Patient Name: _____ _____ _____
Last First M.I.

Home Address: _____
Street Apt# City State Zip

Birth Date: _____/_____/_____ Age: _____ SS # _____-_____-_____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

E-mail: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name: _____ Phone # (_____) _____

Emergency Contact:_____ Phone # (_____) _____

How Would Most Like Us Contact You?: ☐ Cell ☐ Text ☐ E-mail ☐ Home Phone ☐ Work

Primary Care Physician: _____ Phone # (_____) _____

Pharmacy Name: _____ Phone # (_____) _____

Imaging Name: _____ Phone # (_____) _____

Lab Name: _____ Phone # (_____) _____

RELEASE OF INFORMATION: *We will only discuss your protected health information (PHI) with you unless you authorize us to discuss it with someone else. Please list below the name(s) of individuals you authorize our office to discuss your care with. If this list changes, please notify us in writing.*

_____ _____

_____ _____

☐ ***Check if you would like to receive our quarterly health updates.***

I acknowledge that I have been offered a copy of our Notice of Privacy Practices and I have read and understand the above and agree to comply. *(There is a copy of our Notice of Privacy Practices located in our reception area.)*

Patient's Signature: _____ Date: _____/_____/_____

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ANNUAL INTERVAL HISTORY

Thank you for taking the time to fill out the following questions. We use this information to update your medical records.

PLEASE PRINT Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

When was your last Menstrual Period: _____

Type of Contraceptive: _____

Who is your Primary Care Physician? _____ Referring Physician, if any _____

Since your last visit to our office, have you had any significant gynecological problems? (please list)

_____

_____

Since your last visit to our office, have you had any serious illnesses or major surgeries? (please list)

_____

_____

Please list all the medications your are currently taking. Include over the counter medications, herbs, vitamins, diet pills.
• ***Please include hormone replacement and dosage.***

_____ _____

_____ _____

_____ _____

_____ _____

Do yo have any **SIGNIFICANT** problems with the following?

	Yes	No		Yes	No
Weight loss/gain			Nausea/Vomiting		
Fever			Diarrhea		
Fatigue			Bloody stool		
Headaches			Constipation		
Muscle weakness			Abdominal or pelvic pain		
Vision changes			Gas		
Hot flashes/Night sweats			Blood in urine		
Mouth sores			Pain with urination		
Sinusitis			Urgency/Frequency urination		
Ringing in ears			Leakage of urine		
Chest pain			Skin rashes		
Palpitations			Skin ulcers		
Shortness of breath			Easy bruising		
Wheezing/Cough			Swollen glands		
Leg swelling			Blackouts		
Trouble walking			Dizziness		
Depression/Crying			Numbness/Tingling		
Breast pain / Lump/ or Nipple discharge			Sexual problems		
Hair loss			Heavy Periods / PMS		

Signature: _____ Physician signature: _____

Visionary Centre for Women

HEALTH ASSESMENT

Name: _____ **Date:** _____

E-Mail Address: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood (feeling down/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you: