Circle of Life
Women's Center

1525 E. 6000 S. Suite A
South Ogden, UT 84405
Phone: (801) 337-5800
Fax: (801) 337-5809
www.colwc.com

Thank you for trusting us with your health care!

It is important to find a clinic that is both compassionate and professional while still maintaining a relaxing environment. Our philosophy is "***Tenderness with Technology***" and we strive to deliver individualized care with state-of-the-art equipment. If this is your first time with us, welcome and thank you for choosing us! If you are an established patient, thank you for your continued loyalty!

We are staffed by ten providers: five Board Certified Obstetricians/Gynecologists, one Certified Nurse Midwife, three Certified Family Nurse Practitioners, & one Certified Women's Health Nurse Practitioner. While each of our providers strives to be available to their patients as needed, please be aware there may be times when you will need to see one of our other providers. All our exam rooms are equipped with a state-of-the-art ultrasound machine to ensure the highest quality of care. If you have health concerns that are out of our scope of practice, please be aware that we may refer you to the proper specialist to ensure you receive the best care.

We encourage you to follow our social media sites below and to look at our website, www.colwc.com, for additional clinic and health information.

Due to the nature of our practice, there can be daily situations that require schedule changes and/or a delay in your appointment time. Because our providers can be called out for a delivery at a moment's notice, please be prepared for a wait. Please note your appointment is scheduled for an allotted amount of time. Therefore, if there are multiple concerns you would like addressed, please prioritize them before arriving as you may be asked to make a follow-up appointment to continue our assessment & treatment.

***In order to ensure accurate records, we require paperwork to be updated frequently for all of our patients. If you have completed these forms in the past, we ask that you please complete them again simply to ensure we have your health history correct. Therefore, please fill out the enclosed forms (both front & back of each page) in either blue or black ink and bring them to your appointment along with the following:**

- **Your insurance card(s)**
- **A picture ID**
- **Your insurance copay**
- **A list of all of your current medications including the name, strength, and dosage of each. Please ensure the correct spelling of your medications.**

This will help with the registration and check-in process. Please arrive at least 15 minutes early for your appointment.

Your appointment is on _____ at _____am/pm with _____.

Jed Naisbitt MD | David Bierer MD | Julia Johansson MD | Jeffery Brown DO
Brett Larson MD | Karen McBride CNM | Shannon Brennan FNP
Sierra Mayzsak FNP | Kaitlin Ellison WHNP | Laura Blackett FNP

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Patient Information			
Name (Last, First Middle)	SSN #	Birthdate	Sex
Mailing Address	City, State, Zip		
Primary Phone & Type (ex. Cell)	Secondary Phone & Type (ex. Work)	Primary Care Provider	
Marital Status	Smoker Yes / No	Race	Email Address
Employer Occupation	Emergency Contact (person not living with you) Name		
Address	Relationship Address (City/State Only)		
Work Phone	Phone Number		

Spouse (for patients who are married) or Guarantor Information (for patients under 18)			
Name (Last, First Middle)	SSN #	Birthdate	Sex
Mailing Address	City, State, Zip		
Primary Phone & Type (ex. Cell)	Secondary Phone & Type (ex. Work)	Race	
Employer Occupation	Email Address		
Relationship to Patient			

Primary Insurance	
Name of Insurance Company	Policy #
Name of Policy Holder Policy Holder Date of Birth	Group #
Claim Address of Insurance Company	Copay Amount
City, State, Zip	Phone
Relationship to Patient	Effective Date

Secondary Insurance (if applicable)	
Name of Insurance Company	Policy #
Name of Policy Holder Policy Holder Date of Birth	Group #
Address of Insurance Company	Copay Amount
City, State, Zip	Phone
Relationship to Patient	Effective Date

{ } I have current insurance but I choose not to have my insurance billed or use my insurance benefits at this time. I understand that due to certain filing time constraints and pre-authorization requirements, I will be responsible for payment in full for the services rendered. I further release my provider of any obligations under my healthcare plan.

Patient's Initials (only if this option applies):

I agree that all of the information above is accurate and current. I realize my information may be shared with outside entities to assist with treatment, research, and/or collection of payment. I have read & agree to fully comply with the clinic's Financial Agreement.

My signature indicates I fully understand and agree to the above terms. I further grant authorization for treatment for all evaluations & procedures performed and allow the release of information as indicated above.

Signature **Date**

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Circle of Life Women's Center is happy you have chosen us for your care! To make your upcoming appointment more efficient for you as well as your provider, we ask that you fill out the following health history. *Please complete both the front & back of each page* You will notice it also includes areas for the problem you wish to address at your visit and your current medication & supplement list. Please bring this completed document to your appointment so that our staff may meet your needs more accurately. If you need additional space for any of the sections below, please attach a separate sheet. ***Before being taken to our Registration area, this document will need to be completed in its entirety.**

Name: _____ DOB: _____

What is the reason for your visit: _____

MEDICAL HISTORY

Please mark all that apply below.

___ No Known Medical History Problems

	You	Family	Details/Comments
AIDS (HIV)	□	□	_____
Anemia/Blood Disorder	□	□	_____
Asthma	□	□	_____
Blood Clots	□	□	_____
Blood Transfusions	□	□	_____
Breast Disease	□	□	_____
Cancer (If yes, who & what type?)	□	□	_____
Depression/Anxiety (If yes, family history of depression or suicide?)	□	□	_____
Diabetes	□	□	_____
Female/Sexual Problems	□	□	_____
Gall Bladder	□	□	_____
Heart Disease/Stroke/Heart Attack	□	□	_____
Hepatitis	□	□	_____
High Blood Pressure	□	□	_____
High Cholesterol	□	□	_____
Infertility	□	□	_____
Kidney/Bladder/UTI	□	□	_____
Liver Disease	□	□	_____
Neurologic/Epilepsy	□	□	_____
Psychiatric	□	□	_____
Pulmonary Disease	□	□	_____
Rheumatic Fever	□	□	_____
Seasonal Allergies	□	□	_____
Sexual/Domestic Abuse	□	□	_____
Stomach or Bowel	□	□	_____
Thyroid Disease	□	□	_____
Tuberculosis	□	□	_____
Varicose Veins	□	□	_____

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SUBSTANCE USE

	Yes	No	Details/Comments
Alcohol	□	□	_____
Tobacco	□	□	_____
Recreational Drugs	□	□	_____

SEXUAL HISTORY

	Yes	No
Have you ever been sexually active?	□	□
Sexual Concerns:		
Pain with intercourse	□	□
Bleeding with intercourse	□	□
Have you had a new partner in the past year?	□	□
Have you ever had any of the following STD's:		
Chlamydia	□	□
Genital Herpes	□	□
Gonorrhea	□	□
Hepatitis C	□	□
HPV (Cervical Dysplasia or Genital Warts)	□	□
Syphilis	□	□
Trichomonas	□	□
HIV	□	□

Other Sexual Concerns? _____

LIFESTYLE

	Yes	No
Have you ever had a PAP test?	□	□
If yes, have you ever had an abnormal PAP?	□	□
If yes, did you have a Cryo Surgery (freezing of cervix)?	□	□
If yes, did you have a Colposcopy (biopsy of cervix)?	□	□
Have you ever had a mammogram?	□	□
Do you have breast implants?	□	□
Have you ever had a dexascan?	□	□
Have you ever had a colonoscopy?	□	□
Do you perform monthly self breast exams?	□	□
Do you exercise on a regular basis?	□	□

If yes, when & where? _____
If yes, results (if known)? _____
If yes, when, where, & results? _____
If yes, when, where, & results? _____
How many hours of sleep do you receive each night? _____
How often do you wake during the night? _____

Please complete both the front & back sides of each page

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MENSTRUAL HISTORY

	Yes	No
Are you post menopausal?	☐	☐
Have you had a hysterectomy?	☐	☐
Have you had an ablation?	☐	☐

When was the first day of your last period? _____
What was your age of first menses? _____
What is your interval between periods (# of days)? _____
What is your length of your periods (# of days)? _____

Do you have spotting in between your periods?	☐	☐
Do you have any abnormalities?	☐	☐
Excessive Bleeding	☐	☐
Pain	☐	☐
Unusual Discharge	☐	☐

Other Comments/Concerns: _____

BIRTH CONTROL

Current Contraceptive Method:

- ☐ None
- ☐ Oral Contraceptive Pill
- ☐ IUD
- ☐ Depo Provera
- ☐ Nexplanon
- ☐ Nuvaring
- ☐ Condoms
- ☐ Tubal Ligation
- ☐ Essure
- ☐ Hysterectomy
- ☐ Post Menopausal
- ☐ Vasectomy
- ☐ Other: _____

How long have you used your current contraceptive method? _____
Are you satisfied with your current contraceptive method? Yes No
If no, explain? _____
Are you planning a pregnancy? Yes No Uncertain

SURGICAL HISTORY

	Yes	No	Details/Complications
Cardiac Surgery	☐	☐	_____
ENT (Ear/Nose/Throat) Surgery	☐	☐	_____
Lung Surgery	☐	☐	_____
Musculoskeletal Surgery	☐	☐	_____

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	Yes	No	Details/Complications
GU (Genitourinary) Surgery	☐	☐	_____
GI (Gastroenterology) Surgery	☐	☐	_____
GYN (Gynecology) Surgery	☐	☐	_____
Breast Surgery	☐	☐	_____
Other Surgery	☐	☐	_____

PREGNANCY HISTORY

Total # of Pregnancies: _____
# of Births at or past 37 weeks gestation: _____
# of Births less than 37 weeks gestation: _____
Forceps used? Yes No Vacuum used? Yes No
# of Cesarean Deliveries: _____
# of Miscarriages: _____
# of Abortions: _____
Did you have any of the following pregnancy complications:

	Yes	No	Details/Comments
Preterm labor	☐	☐	_____
Recurrent pregnancy loss	☐	☐	_____
Still birth	☐	☐	_____
Gestational diabetes	☐	☐	_____
High blood pressure or pre-eclampsia	☐	☐	_____
Twins or triplets	☐	☐	_____
Abnormal bleeding	☐	☐	_____
Very large baby	☐	☐	_____
Growth restricted baby	☐	☐	_____
Birth defect	☐	☐	_____
Other complications	☐	☐	_____

MEDICATIONS

Please list all of your current medications (prescribed & over the counter). Many medications have similar spelling so please confirm the list below with your actual medication bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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PREFERRED PHARMACY

Which pharmacy do you prefer we use for any prescriptions/medications we may prescribe?
Name: _____
Address: _____

SUPPLEMENTS

Please list all of your current supplements. Many supplements have similar spelling so please confirm the list below with your actual supplement bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*

ALLERGIES

Please list all of your current allergies:

_____
_____
_____

VACCINATIONS

	Yes	No	Unknown
Have you ever been vaccinated for Hepatitis A or B?	□	□	□
Have you had a tetanus shot within the last 10 years?	□	□	□
Have you had the Gardasil series?	□	□	□

Please note your appointment is scheduled for an allotted amount of time. In order for us to remain on schedule, if there are multiple problems you need to address, please prioritize what you wish to discuss today. We will ask you to make a follow-up visit to continue our assessment & treatment for any remaining problems until we have assisted you with all of your concerns. Thank you for assisting us to give you our best & most efficient care!

Please complete both the front & back sides of each page