Lifespan Physician Group, Inc.
Obstetrics & Gynecology
Delivering health with care®

148 West River Street
Providence, RI 02904
1st Floor – Suite 8
(401) 606-3800

Dear _____,

Welcome to the **Menopause Consultation Program**.

Your appointment is on _____ at _____ am/pm

with _____ of the Menopause Consultation Program

in **Suite 8 on the 1st Floor**.

Please arrive by _____ for registration.

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.
Please do not mail your packet back to us.

Please arrive 15 minutes prior to your appointment time to complete registration.

If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance.

Please Note: If you arrive later than 15 minutes for your appointment time, you may have to reschedule your appointment.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

We look forward to seeing you.

Sincerely,
Menopause Consultation Program Team

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DRIVING DIRECTIONS

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 148 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street / RI-246
- Turn left onto West River Street
- 148 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right to stay on West River Street
- 148 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 148 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

We are located on the First Floor in Suite # 8

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Patient Label

Menopause Consultation Program First Floor-Suite 8
148 West River Street, Providence, RI 02904

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone ( )

City	State	Zip Code	Mobile Phone ( )

Marital Status
❑ Single ❑ Married ❑ Divorced ❑ Legally Separated
❑ Widowed ❑ Significant Other ❑ Other:_____

Preferred Language
Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Sex: ❑ Female ❑ Male

Religion: _____

Preferred Pharmacy: Name: Phone #:
Address:

Are you Employed? ❑ YES, Full Time ❑ YES, Part Time ❑ YES, Self-employed ❑ Student, Full Time
❑ NO, Not Employed ❑ NO, Disabled ❑ NO, Retired ❑ Student, Part Time

Employer	Occupation	Employer Phone ( )

Which provider you are here to see today?

How did you hear about us?

Primary Care Provider (PCP) / Practice Name

PCP Address	PCP Phone ( )

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed

Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Mobile Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT PORTAL: Would you like access to the MyLifespan Patient Portal? ❑ Yes ❑ No

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration designating another person to be your agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

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Name:

DOB:

MRN:

ETHNICITY – PLEASE SELECT

We want to make sure that all our patients get the best care possible. Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

❑ Hispanic or Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Prefer not to answer

RACE - PLEASE SELECT

❑ Unknown

❑ Prefer not to answer

❑ American Indian or Alaska Native

❑ Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)

❑ Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)

❑ Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)

❑ White or Caucasian

❑ Other: _____

PHONE PRIVACY

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

HOME telephone # (_____) _____

MOBILE telephone # (_____) _____

WORK telephone # (_____) _____

BEST number to reach you: ❑ Home ❑ Mobile ❑ Work

May we leave a **general** message about appointments? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

May we leave a **detailed** message? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

Menopause Consultation Program
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MEDICAL HISTORY QUESTIONNAIRE

PLEASE FILL OUT ALL FORMS AND BRING TO YOUR APPOINTMENT
Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name: _____ First: _____ DOB: _____
Preferred Language Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Your Physicians
Primary Care Provider_____ Date last seen: _____
GYN Provider_____ Date last seen: _____
Other Providers/Specialists:
Name _____Specialty_____ Date last seen: _____
Name _____Specialty_____ Date last seen: _____
Name _____Specialty_____ Date last seen: _____
Which provider referred you to see us? _____
Briefly describe the reason for your referral and your current symptoms:

List all MEDICATIONS (please include non-prescription drugs)

Medication	Dose	Frequency	Reason you take this

List all ALLERGIES:

Medication/Food	Reaction

Past Medical History (please check all that apply)

□ Diabetes □ High Blood Pressure □ Heart Attack □ Stroke □ Blood Clot
□ Kidney Disease □ Liver Disease □ Thyroid Disease □ Seizures □ Asthma
□ Anemia □ Depression □ Anxiety □ Bone Fracture
□ Bleeding tendency (describe): _____
□ Problems receiving anesthesia (describe): _____
□ Cancer (type) _____ □ Other _____

Screenings

Colonoscopy: Date: _____ Result: _____
Last Mammogram: Date: _____ Result: _____
Bone Density: Date: _____ Result: _____

Surgical History (please list procedure and date)

_____ _____
_____ _____
_____ _____

Have you ever received a blood transfusion? □ Yes □ No If yes, year _____
Have you had a hysterectomy? □ Yes □ No If yes, reason _____
Were your ovaries removed? □ No □ Yes (one) □ Yes (both)

OB/GYN HISTORY:

Number of pregnancies: _____ Number of live births: _____ Miscarriages: _____ Abortions: _____
Last menstrual period: _____ Age at first period: _____ Occurs every ____ days
Any abnormal bleeding ? □ No □ Yes (describe) _____
Age at last period: _____ □ N/A
Birth Control: □ used in the past □ currently use (type) _____
Hormone Replacement Therapy: □ used in the past □ currently use (type) _____
Last Pap smear: _____ Result: _____
Any abnormal PAP smears in the past? □ No □ Yes

Lifestyle and Personal Habits

Who do you live with at home? _____ Your occupation _____
Do you/have you ever smoked cigarettes? □ Yes □ No If yes, _____ packs/day for _____years Quit date _____
Do you drink alcohol? □ Yes □ No If yes, number of drinks/week _____
Do you use any recreational drugs? □ Yes □ No If yes, what type? _____
Have you ever been treated for problems with alcohol or drugs? □ Yes □ No

Cancer Family History

Thinking about <u>all</u> your BLOOD relatives from your mother and father's family, please indicate if anyone has/had any of the following. If yes, please write their relationship to you.
For example: mother's cousin, father's aunt, etc.

Condition			Relationship to You	
Breast cancer	❑ No	❑ Yes		
Ovarian cancer	❑ No	❑ Yes		
Uterine cancer	❑ No	❑ Yes		
Endometrial cancer	❑ No	❑ Yes		
Colorectal cancer	❑ No	❑ Yes		
Other cancer	❑ No	❑ Yes		Describe:

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REVIEW OF SYSTEMS

Patient Name: Date of Birth:

REVIEW OF SYSTEMS: Please indicate all that apply to you.

Constitutional Symptoms	Y	N	**Head and Neck**	Y	N
Weight gain/loss			Dizziness/Vertigo		
Fevers			Double vision		
Night sweats			Any vision changes		
Daytime hot flashes			Nose bleeds		
Fatigue			Sore throat/Pain swallowing		
Loss of appetite					
Cardiac	Y	N	**Respiratory**	Y	N
Chest pain/heaviness			Cough		
Shortness of breath with activity			Wheeze		
Shortness of breath at rest			Shortness of breath		
Irregular heart beat/Palpitations			Blood in sputum		
Lightheadedness/Fainting			Early waking/Snoring		
Gastrointestinal	Y	N	**Genitourinary**	Y	N
Abdominal pain			Frequent voiding		
Nausea/Vomiting			Pain with voiding		
Heartburn			Blood in urine		
Constipation or Diarrhea			Vaginal dryness		
Blood with stools			Sexual dysfunction		
			Pain with sexual activity		
Endocrine	Y	N			
Heat/cold intolerance			**Hematologic**	Y	N
Excessive thirst			Abnormal bleeding/bruising		
Excessive voiding			Clotting problems		
Excessive appetite			Transfusion problems		
Excessive hair growth			Anemia		
			Blood clots		
Musculoskeletal	Y	N			
Joint pain/swelling			**Neuro-Psychiatric**	Y	N
Stiffness			Seizures		
Weakness of limbs			Numbness		
Back pain/Sciatica			Weakness		
Gout			Depression		
			Anxiety		
Ob-Gyn	Y	N			
Pregnancies If yes, how many?_____			**Breast Health**	Y	N
Live births If yes, how many?_____			Breast cysts/lumps		
C-section If yes, how many?_____			Breast skin changes		
Menstrual period regular			Nipple discharge		
Postmenopausal Last Period:_____			Breast pain		
Postmenopausal bleeding			Recent mammogram		
Recent PAP Smear					

Provider Notes
Please do not write in this area.

Thank you for providing us with this important information.

Patient's Signature: _____ Date: _____

Women's Health Initiative Insomnia Rating Scale

NAME: _____ Date of Birth: _____

In the past 4 weeks (Please circle your answer):

Did you take any kind of medication or alcohol at bedtime to help you sleep?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you nap during the day?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you have trouble falling asleep?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you wake up several times at night?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you wake up earlier than you planned to?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you have trouble getting back to sleep after you woke up too early?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you snore?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.
(5) I don't know

Overall, was your typical night's sleep during the past 4 weeks:
(0) very sound or restful
(1) sound or restful
(2) average quality
(3) restless
(4) very restless?

About how many hours of sleep did you get on a typical night during the past 4 weeks?
(0) 10 or more hours
(1) 9 hours
(2) 8 hours
(3) 7 hours
(4) 6 hours
(5) 5 or less hours.

Levine DW, Kripke DF, Kaplan RM, et al. Reliability and Validity of the Women's Health Initiative Insomnia Rating Scale. Psychol Assess 2003;15:137-148.