

Becton Women's Clinic

Paul Becton, Jr. M.D.

1000 West Kingshighway, Suite 6
AMMC Professional Office Building
Paragould, AR. 72450
870.236.9988

(Please Print)

Date: _____ Social Security Number: _____ - _____ - _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Msg: _____

Work Phone: _____ Ext: _____

Patient Place of Employment: _____

Date of Birth: _____ Marital Status: _____

Email Address: _____

SPOUSE INFORMATION:

Last Name: _____ First Name _____ Middle Initial: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Place of Employment: _____ City: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone: _____ Cell: _____

REFERRING PROVIDER:

Name: _____ Location: _____

PRIMARY INSURANCE:

Insured's Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Relationship to Patient: _____

Social Security Number: _____ - _____ - _____

Insurance Company: _____

Address: _____

I.D. #: _____ Group #: _____

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996, (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Arkansas Act 134 of 2005

Arkansas Act 134 of 2005 prohibits the smoking of tobacco anywhere on the grounds of a medical facility. A violation of this law is a class C misdemeanor. Please acknowledge that you have been informed of the law by initialing below.

____ I understand and agree to abide by the provisions of Arkansas Act 134 of 2005, which prohibits the smoking of tobacco anywhere on the grounds of a medical facility.

PATIENT SIGNATURE: _____ **Date:** _____

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Paul Becton, Jr. M.D.
Brandy Acuff, APN

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PATIENT HEALTH INFORMATION

Today's Date: _____

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

Address: _____

Date of Birth: _____ Social Security: _____ - _____ - _____

Phone: _____ Cell: _____

Work: _____ Message: _____

CONFIDENTIAL AND PERSONAL HEALTH INFORMATION

Thank you for allowing us to take part in your health care. Please fill out the following questionnaire. You will have adequate opportunity to discuss in detail any part of your history and medical concerns you may have with the doctor or nurse. You will also have the opportunity to ask questions which may be troubling you.

- Have you previously been seen by Dr. Becton? Yes No
- What medications are you currently taking and have been in the past?

Medication and Dose

Medication and Dose

- Have you ever had any allergies, reactions, or other side effects from any medications, vaccines, chemicals or any other agents: Yes No
If yes, please list: _____

- Please briefly state the reason for today's appointment: _____

- Do you have a family physician? Yes No If yes, whom? _____

GYNECOLOGY HISTORY

1. Please indicate the birth control methods used at present:

Pill Diaphragm Rhythm Tubes Tied Vasectomy
 IUD Condoms None Withdrawal Norplant
 Other Depo Provera Foam/Contraceptive Film Sponge

When was your last pap smear done? _____ By Whom? _____

Was your last pap smear normal? Yes No

When was your last breast exam? _____ Was it normal? Yes No

Do you carry out self-breast exams? Yes No

Most recent mammogram? _____ Where was it done? _____

2. (If Menopausal, please omit this section)

Age periods began? _____ Date of first day of last menstrual period? _____

Are your periods: Regular Somewhat irregular Completely irregular

Was your last period normal? Yes No How long did it last? _____

Menstrual flow usually lasts for a total of _____ days.

Menstrual flow: Number of pads per day: _____ Number of tampons per day: _____

Are your periods usually painful? Yes No If yes, please rate below.

Mild Moderate Severe Incapacitating

3. If no longer menstruating, please indicate reason:

Menopausal Hysterectomy Reason Unknown Other

At what age was your last period? _____

Have you had any bleeding or spotting since menstruation stopped? Yes No

Do you have night sweats? Yes No or Dry Vagina? Yes No

Do you have any hot flashes? Yes No

OBSTETRICAL HISTORY

How many: a) Times have you been pregnant? _____
b) Full term (9 month) babies? _____
c) Premature babies? _____
d) Miscarriages? _____
e) Elective abortions? _____
f) Present children living? _____

PREVIOUS HOSPITALIZATIONS

Please include all admissions for surgery or medical problems. Also include all outpatient surgeries.

Approx Year.	Hospital	Reason for Admission
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Have your grandparents, parents, uncles, aunts, brothers, sisters, or children ever been treated for:
Mark X if yes and indicate which relative is involved.

_____ Cancer _____	_____ Epilepsy _____
_____ Tuberculosis _____	_____ Depression _____
_____ Heart Disease _____	_____ Glaucoma _____
_____ Kidney Disease _____	_____ Intestinal Disorders _____
_____ High Blood Pressure _____	_____ Blood Disease _____
_____ Hay Fever or Asthma _____	_____ Neurological Disorder _____
_____ Diabetes _____	_____ Muscular Disorder _____

MARITAL STATUS

Please indicate current marital status: _____ Single _____ Married _____ Divorced _____ Separated
_____ Widowed _____ Living with Partner

Husband: Age _____ Name: _____

PERSONAL HISTORY

Occupation: _____ Husband's Occupation: _____

Do you smoke? ____ Yes ____ No If yes, how many years? ____ yrs.
How many packs per day? ____ Do you understand the harmful effects of smoking? _____

Do you habitually use laxatives? ____ Yes ____ No Do you drink alcohol? ____ Yes ____ No

Do you use caffeine? ____ Yes ____ No If yes, how many servings per day? _____

Other drugs? _____

When was your last general physical examination? _____

HEALTH HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Red Measles | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lumps in Breast |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> STD |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Rapid or irregular
heartbeat | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Frequent or severe
abdominal pain | <input type="checkbox"/> Mental Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent or severe
allergies | <input type="checkbox"/> Chronic recurrent
diarrhea | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Other rectal trouble | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bleeding Problem |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Phlebitis/Clots |
| <input type="checkbox"/> Frequent or severe
headaches | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Serious Head Injury | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Other serious injury | <input type="checkbox"/> Pelvic Pain | |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumor of any kind | |
| | <input type="checkbox"/> Skin Problems/Acne | |

PRESENT HEALTH As of **NOW**, do you have any of the following symptoms?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Chills/Fever | <input type="checkbox"/> Cough | <input type="checkbox"/> Recent weight | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Shortness of |
| <input type="checkbox"/> Sudden urges to urinate | <input type="checkbox"/> Heart Skipping | <input type="checkbox"/> Swelling in neck | <input type="checkbox"/> Breath |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Heart racing | <input type="checkbox"/> Pain w/intercourse | <input type="checkbox"/> Unusual hair |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Depression | <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Abnormal vaginal |
| <input type="checkbox"/> Excess weakness | <input type="checkbox"/> Swelling under groin or arm | <input type="checkbox"/> Vaginal irritation | <input type="checkbox"/> bleeding |
| <input type="checkbox"/> Lumps in breast | <input type="checkbox"/> Test positive for HIV or Hep B | <input type="checkbox"/> Bleeding after intercourse | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Headaches | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Sugar in urine | | <input type="checkbox"/> Pelvic Pain | |
| <input type="checkbox"/> Dizziness | | | |
| <input type="checkbox"/> Abdominal cramps | | | |
| <input type="checkbox"/> Constipation | | | |
| <input type="checkbox"/> Nausea/Vomiting | | | |
| <input type="checkbox"/> Diarrhea | | | |
| <input type="checkbox"/> Swelling in feet, hands or face | | | |

Any other health concerns you would like us to be aware of?
