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

MENOPAUSE CONSULTATION PROGRAM

148 West River Street, Suite 8
Providence, RI 02904
401-606-3000
www.WomensMedicine.org

Dear _____,

Welcome to the **Menopause Consultation Program.**

Your appointment with _____ is on _____at _____am/pm. at
☐ 148 West River Street, Providence, RI **Second floor, Suite 8.**
☐ 1377 South County Trail, Unit 2A, East Greenwich, RI

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and any pertinent medical records with you on the day of your appointment. The information requested is important for your care. We appreciate you taking the time to complete all the paperwork and bringing it to with you to your appointment. **Please do not mail your packet back to us.**

For your convenience we have enclosed driving directions to our offices. Park in the South Lot. For more information about the Pelvic Pain Program, please visit our website at www.WomensMedicine.org.

Please arrive 15 minutes prior to your appointment time for registration. Please Note: If you arrive later than 15 minutes for your appointment time, you may have to reschedule your appointment. Call us at (401)606-3000 if you have any questions.

Lifespan Physician Group monitors and manages missed appointments to ensure that we are able to provide all our patients with timely access to our health care providers. High numbers of unused appointments delay necessary medical care for patients.

As a result, we request one business days' notice to cancel an appointment. Without appropriate notice, you may be charged a missed appointment fee.

Missed First Appointment:	$100
Missed Appointment:	$ 50
Missed Testing Procedure	$100

We look forward to seeing you.

Sincerely,

The Menopause Consultation Program Team

REFERRALS IF YOUR INSURNACE REQUIRES A REFERRAL, YOU MUST GIVE ONE TO THE RECEPTIONIST ON THE DAY OF YOUR APPOINTMENT OR YOU WILL BE RESPONSIBLE FOR THE FEE.

11.11.19

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Patient Label

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 ❑ Life Partner ❑ Civil Union
Spouse: Name _____ DOB _____

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

Sex Assigned at Birth: ❑ Female ❑ Male Gender Identity: _____ Pronouns: _____
Religion: _____
Race (circle one): American Indian / Alaskan Native / American Indian & Native Hawaiian / Asian / Asian & American Indian / Asian & Native Hawaiian / Black & Asian / Black & American Indian / Black & Native Hawaiian / Black-African American / White / White & American Indian / White & Asian / White & Black / White & Native Hawaiian / Other **Hispanic/Latino** (circle one): Hispanic / Non-Hispanic

Are you Employed? ❑ YES ❑ NO	Employer	Occupation

Full Time or Part Time	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
	( )

Preferred Pharmacy: Name: Phone #:
Address:

INSURANCE INFORMATION

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 _____

Gender of Subscriber

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

Gender of Subscriber

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

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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REVIEW OF SYSTEMS

Patient Name: Date of Birth:

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

Constitutional Symptoms	Y	N
Weight gain/loss		
Fevers		
Night sweats		
Daytime hot flashes		
Fatigue		
Loss of appetite		
Cardiac	Y	N
Chest pain/heaviness		
Shortness of breath with activity		
Shortness of breath at rest		
Irregular heart beat/Palpitations		
Lightheadedness/Fainting		
Gastrointestinal	Y	N
Abdominal pain		
Nausea/Vomiting		
Heartburn		
Constipation or Diarrhea		
Blood with stools		
Endocrine	Y	N
Heat/cold intolerance		
Excessive thirst		
Excessive voiding		
Excessive appetite		
Excessive hair growth		
Musculoskeletal	Y	N
Joint pain/swelling		
Stiffness		
Weakness of limbs		
Back pain/Sciatica		
Gout		
Ob-Gyn	Y	N
Pregnancies If yes, how many?		
Live births If yes, how many?		
C-section If yes, how many?		
Menstrual period regular		
Postmenopausal Last Period:		
Postmenopausal bleeding		
Recent PAP Smear		

Head and Neck	Y	N
Dizziness/Vertigo		
Double vision		
Any vision changes		
Nose bleeds		
Sore throat/Pain swallowing		
Respiratory	Y	N
Cough		
Wheeze		
Shortness of breath		
Blood in sputum		
Early waking/Snoring		
Genitourinary	Y	N
Frequent voiding		
Pain with voiding		
Blood in urine		
Vaginal dryness		
Sexual dysfunction		
Pain with sexual activity		
Hematologic	Y	N
Abnormal bleeding/bruising		
Clotting problems		
Transfusion problems		
Anemia		
Blood clots		
Neuro-Psychiatric	Y	N
Seizures		
Numbness		
Weakness		
Depression		
Anxiety		
Breast Health	Y	N
Breast cysts/lumps		
Breast skin changes		
Nipple discharge		
Breast pain		
Recent mammogram		

Provider Notes
Please do not write in this area.

Thank you for providing us with this important information.

Patient's Signature: _____ Date: _____

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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:

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.

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Lifespan Physician Group-Obstetrics & Gynecology's Providence office has moved to 148 West River St., Suite 8, Providence, RI 401-606-3000

It is best to enter the building from the South Entrance. We are located on the first floor off the main hallway.

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). *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).

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).

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). *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.*

BUS ROUTES
Best services to take are **Route# 58** to Corliss Street and West River Street or **Route# 72** to Charles Street and West River St.
Route# 58: Get off at bus stop near Stop & Shop. Walk down the hill to the corner of Corliss Street and West River Street, take a right onto West River Street. Our building is a brick mill building on the right. Enter through the South parking lot entrance.
Route# 72: Get off at bus stop in front of the Providence Post Office (across the street from the "Subway" sandwich shop). Walk to the corner of Charles Street and West River Street, take a right onto West River Street and walk straight down to our building. It is a brick mill building on the left. Enter through the South parking lot entrance.
Contact RIPTA at (401) 781-9400 or online at www.ripta.com for schedules and additional information.

EAST GREENWICH, RI 02818
WEST BAY MEDICAL OFFICE CONDOMINIUMS
1377 SOUTH COUNTY TRAIL UNIT 2A
401-606-3000

FROM 95 NORTH: Merge onto RI-2 S via EXIT 8A toward RI-4/East Greenwich. Drive 0.56 miles. We are the second driveway on the right after CVS Pharmacy, just past New England Tech Boulevard. *If you reach Pine Glen Drive you have gone too far.*
FROM 95 SOUTH: Merge onto RI-2 via EXIT 8 toward East Greenwich/West Warwick. Drive 0.91 miles. We are the second driveway on the right after CVS Pharmacy, just past New England Tech Boulevard.
FROM Take RI-4 N: Merge onto Division Rd/RI-401 W via EXIT 8B toward RI-2 S/I-95 S. Drive 0.77 miles. Turn left onto Quaker Ln/RI-2. Continue to follow RI-2. Drive 0.23 miles to 1377 South County Trail is on the right past Dave's Market.

EAST PROVIDENCE, RI 02914
900 WARREN AVENUE, SUITE 101
401-606-3000

FROM 95 NORTH or SOUTH VIA 195: Take 195 East. Get off at Exit 2C. At traffic light, turn left onto Warren Ave. Office approx. ¼ miles on the left. Go slightly past Chelo's Restaurant to the light at the Extended Stay America Hotel. Turn left at that light into the parking lot. Follow around to the left. 900 Warren Avenue (Coastal Medical Building) is the last building in the lot.
FROM MASSACHUSETTS via 195: Take 195 West. Take Exit 1 in Seekonk. At the end of exit, turn right. At first light, take a left. (Pass Lucky's Bar and Grill on left). Go under the overpass and bear to your right onto Warren Ave. Take a right at first light at the Extended Stay America Hotel. Follow around to your left. 900 Warren Avenue (Coastal Medical Building) is the last building in the lot.
FROM THE "EAST BAY": Take Route 114 North towards Providence. Bear right at Mobil Station and follow 114A. Drive approx. ½ mile and you will come to Route 6. Turn left onto Route 6 going West. Continue on into Rhode Island (through several lights). Turn right at light at the Extended Stay America Hotel. Follow around to your left. 900 Warren Avenue (Coastal Medical Building) is the last building in the lot.

NORTH ATTLEBORO, MA 02760
6 WHIPPLE STREET
401-606-3000

FROM 95 NORTH: Take Exit 2B (South Attleboro) and continue on RT. 1A past Emerald Square Mall. Office is on left hand side across the street from Showcase Cinemas.
FROM WOONSOCKET: Take 295 to RT. 1 exit. North onto RT. 1. Office is ½ mile on left, across the street from Showcase Cinemas.

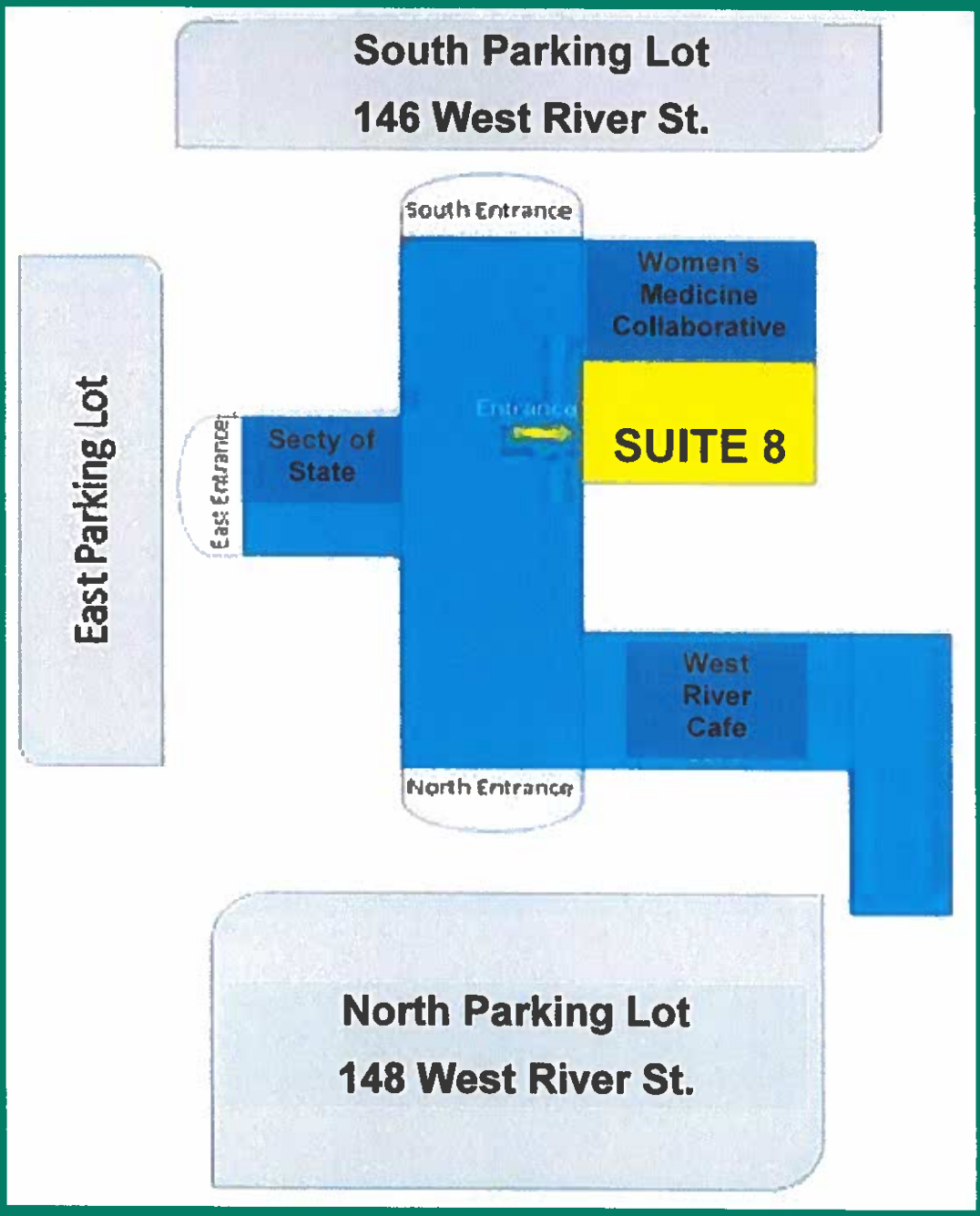
1/21/2020

LPG - Obstetrics & Gynecology

148 West River Street - Suite 8, Providence, RI 02904

Our suite is accessible from all West River building entrances.

Our suite is on the 1st floor, closest to the SOUTH entrance.



To access our 2nd floor:

Once in our suite, take the elevator located on the right, just past the first check-in window.