Sweetwater Medical Associates

16651 Southwest Freeway, Suite 100
Sugar Land, Texas 77479

Well Woman Exam

Patients, please read before signing this form.

Thank you for scheduling your Well Woman Exam with our clinic. This exam is conducted in our office much as it would be in a gynecologist's office and includes the same elements in the exam. These are:

- Breast Exam
- Pelvic Exam
- Pap Smear
- Urinalysis
- Birth control or hormone replacement therapy

Due to restrictions by your insurance company, we cannot address medical problems outside of the above-mentioned list, which constitutes a "Well Woman Exam." Most insurance companies will pay for only one type of visit in a day: either a well/physical exam or an illness/problem exam. Also note, that most insurance companies will not pay for more than one Well Woman Exam per calendar year, while others will only pay for one every 365 days. Should your insurance company not allow coverage for today's exam or testing that is part of the exam, such as the HPV test, which is recommended for women ages 30 and above, due to these or any other factors, you will be responsible for payment. **If you decide not to receive one of the exams or tests recommended during your Well Woman Exam, please note that determining medical conditions may not be targeted and will not allow early symptoms and concerns to be evaluated.**

********BY SIGNING BELOW, I AGREE THAT ANY SYMPTOMS, MEDICAL PROBLEMS, AND/OR LABS NOT ASSOCIATED WITH THE ABOVE-MENTIONED LISTING, THAT ARE REQUESTED BY ME TODAY ARE MY RESPONSIBILTY TO PAY AT TIME THE SERVICES ARE RENDERED. I WILL THEN RECEIVE AN INVOICE TO SEND TO MY INSURANCE COMPANY FOR DOCUMENTATION PURPOSES AND WITH SOME COMPANIES, POSSIBLE REIMBURSEMENT. I UNDERSTAND YOUR OFFICE WILL NOT BE ABLE TO HONOR INSURANCE ADJUSTMENTS ON THIS SERVICE AND THAT YOUR OFFICE WILL BE UNABLE TO FILE FOR THE SYMPTOM VISIT AS MOST INSURANCE COMPANIES GENERALLY WILL NOT PAY FOR BOTH A SYNPTOM VISIT AND PHYSICAL IN THE SAME DAY. *********

If you have a new or acute medical condition that you feel needs to be addressed today, please notify the medical assistant and we will help you reschedule your Well Woman Exam to another time. This will allow us to evaluate your acute problem today.

Thank you for your understanding and cooperation in this matter.

Jeffery T. Alford, MD
Dina B. White, MD

_____
Date

_____
Patient Name

_____
Medical Assistant Signature

_____
Patient Signature

Breast Cancer Risk Survey

Patient Name:_____ **Date**: _____

Patient Instructions:

While you are waiting to see the physician, we ask that you complete the survey below. It will help us to assess your risk for developing breast cancer. Thank you.

Have you ever had breast cancer? **Yes** _____ **No** _____
If you checked "**Yes**" you have completed this survey. Please give the survey to your health care provider.

1. Have you ever had a breast biopsy that showed lobular carcinoma in situ (LCIS) or ductal carcinoma in situ (DCIS)? **Yes** _____ **No** _____ **Don't Know** _____

2. How old are you? _____

3. How old were you when you had your first menstrual period? _____

4. How old were you when your first child was born? (If you never had a child, enter "0".) _____

5. How many of your sisters, daughters, or mother have had breast cancer? _____

6. Have you ever had a breast biopsy? (A breast biopsy is when the doctor removes tissue from your breast to test for cancer.) **Yes**_____ **No**_____ **Don't Know** _____

   6a. If yes, how many breast biopsies have you had? _____

   6b. Did the doctor ever tell you that one of your biopsies showed atypical hyperplasia (a precancerous condition)? **Yes**_____ **No**_____ **Don't Know**_____

7. What is your race? White_____ Black_____ Asian_____

Thank you for completing this survey. Please give the survey to your health care provider. The doctor will discuss the results with you.

Health Care Provider Instructions:
Please use this survey in conjunction with the Gail Model Risk Assessment Tool.

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration: