

# *Santa Cruz Naturopathic Medical Center*



Hello-

Welcome to the Santa Cruz Naturopathic Medical Center! You can read more about us and our center at [www.scnmc.com](http://www.scnmc.com).

Attached are forms to complete before your appointment. Please bring these completed forms with you at the time of your appointment, and also bring any medications, herbs, and/or supplements you are currently taking. Please also bring copies of any recent laboratory test results. If you have had labs but do not have the results, we will have you sign a release of record and we can obtain those for you. Please refrain from intercourse or using tampons 24 hours before your exam. If you are a menstruating woman, it is ideal to have your exam done mid-cycle around ovulation.

Your **Women's Wellness Exam** will take one hour, and includes a general intake and physical exam to include vitals, listening to your heart and lungs, a breast exam, pelvic exam and pap smear. The cost is \$150, plus the lab fee that will be billed separately. Payment is due in full at the time of the visit. If you have insurance, we will submit a bill to your insurer on your behalf requesting reimbursement for the office visit. You may or may not receive partial reimbursement, depending on your insurance provider and your particular plan.

Our clinic is located at 736 Chestnut Street in Santa Cruz, CA 95060. If you need further directions, or if you have any questions, please don't hesitate to call.

We look forward to seeing you at your appointment and partnering with you in your health.

**Please note:**

**If you need to cancel your appointment, we require a 24 hour notice. You will be charged a \$75 cancellation fee for a missed appointment or cancelling with less than 24 hour notice.**

All the best,

Sarah Hellman  
Office Manager

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

*736 Chestnut Street, Santa Cruz, CA 95060*  
*Ph: (831) 477.1377 ♦ Fax: (831) 477.0425*  
[www.scnmc.com](http://www.scnmc.com)

**SANTA CRUZ NATUROPATHIC MEDICAL CENTER**  
**736 Chestnut Street, Santa Cruz, CA 95060 831.477.1377**  
**BIOGRAPHICAL INFORMATION FORM – GYN ADULT**

Date: \_\_\_\_\_

**Personal History:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street and Number City State Zip

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Race: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Business: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

**List Yes (Y), No (N), or Past (P) regarding the use of the following:**

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day / Number of years \_\_\_\_\_

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes / Past: \_\_\_\_\_

Soda: Y N P Ounces per day if Yes / Past: \_\_\_\_\_

Alcohol: Y N P How often & how much if Yes / Past: \_\_\_\_\_

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P Any Drug Treatment: Y N P

How did you hear about our center, or who referred you? \_\_\_\_\_

**Health Concerns:**

List in order of importance your primary health concerns:

How long have these problems persisted?

1) \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

\_\_\_\_\_

Under what conditions do your problems usually get worse?

Under what conditions do they improve?

1) \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

\_\_\_\_\_

**SANTA CRUZ NATUROPATHIC MEDICAL CENTER  
BIOGRAPHICAL INFORMATION FORM - GYN**

Your primary physician and/or gynecologist:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

When was the first day of your last period? \_\_\_\_\_

When was your most recent pap smear? \_\_\_\_\_

Have you ever had an abnormal pap? \_\_\_\_\_

If so, when & did you receive any treatment? \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_

Do you have any family history of breast cancer? If so, whom?

\_\_\_\_\_

**Medications**

What medications are you currently taking?

Medications	Dosage	For What	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any supplements you are currently taking:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any known allergies to food or medicines:

\_\_\_\_\_

