PHOENIX WOMEN'S CLINICS

MALE INTAKE FORM

For Office Use Only:
-Place processing label here –

Date: _____ **Location:** ☐ 7th Street ☐ McDowell ☐ Hope Mobile

Identifying Data (please print)

Name: *Last:* _____ *First:* _____

Date of Birth: *MM / DD / YEAR* ___/___/___ *Age:* _____

Street Address: _____ **Zip:** _____

Phone: ( ) _____ - _____ *Consent to Call or Text* ☒

Email: _____ @ _____

Reason for Visit: ☐ STI/STD test ☐ Office Visit ☐ Other

1st visit to PWC? ☐ *No* ☐ *Yes*

Symptoms: *(Check all that apply)* ☐ None ☐ Body Rash ☐ Genital Rash ☐ Sores or Lesions ☐ Discharge ☐ Penile Itch ☐ Pain with Urination ☐ Other: _____

Pharmacy: (*Name & Address*) _____

How did you hear about us? ☐ Radio ☐ Google/online ☐ Clinic/Agency ☐ Friend/Family ☐ Signage ☐ Other: _____

Demographic Data:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Cohabitation

Family Size: _____ *(Total # in family)* Name of Spouse or Partner: _____

Monthly Income: ☐ $0-$5,000 ☐ $5,001-$10K ☐ $10,001-$15K ☐ $15,001-$20K

Race/Ethnicity: ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian

Religion: _____

Have Health Ins.? ☐ Yes ☐ No

Occupation: _____ **Last year of school completed:** _____

Patient History:

Allergies: (drug/food/environment) ☐ None known ☐ Yes, List: _____

Current Medications: ☐ None ☐ Yes, List: _____

Chronic Health Problems: ☐ None ☐ Yes, List: _____

Family History:

Parents: ☐ None ☐ Unknown ☐ Cancer ☐ Diabetes ☐ Heart ☐ Thyroid ☐ Other: _____

Grandparents: ☐ None ☐ Unknown ☐ Cancer ☐ Diabetes ☐ Heart ☐ Thyroid ☐ Other: _____

Social History:

Alcohol: ☐ None - or - Type: _____ Amount: _____ ☐ Daily ☐ Weekly ☐ Monthly

Tobacco/Vape: ☐ None - or - Type: _____ Amount: _____ ☐ Daily ☐ Weekly ☐ Monthly

Drugs: ☐ None - or - Type: _____ Amount: _____ ☐ Daily ☐ Weekly ☐ Monthly

Last sexual intercourse: ___/___/___

Number of sexual partners in the last 12 months: _____ **Sex with Male partners:** ☐ No ☐ Yes

Sexually Transmitted Infection (STI) History:

	No	Yes	*if Yes, Date:*
Syphilis	☐	☐	___/___/___
Gonorrhea	☐	☐	___/___/___
Chlamydia	☐	☐	___/___/___
Herpes	☐	☐	___/___/___

	No	Yes	*if Yes, Date:*
HPV	☐	☐	___/___/___
Other: _____	☐	☐	___/___/___
Other: _____	☐	☐	___/___/___
Other: _____	☐	☐	___/___/___

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For Office Use Only:					
BP:	*PR*	*LK*	*Nit*	*BL*	*GL*
P:					
WT:					

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Phoenix Women's Clinic is not an emergency clinic and does not have a 24-hour answering service.

PLEASE READ AND SIGN AUTHORIZATION FOR SERVICES

- I hereby request services at Phoenix Women's Clinic for medical treatment and counseling. I understand that Phoenix Women's Clinic medical services are provided by a nurse practitioner, nurse and/or volunteer physicians. I understand that the scope of Phoenix Women's Clinic services is limited, and that if follow-up care is needed I will be referred to appropriate health care providers. I further understand it is my responsibility to obtain any follow-up care.
- The counseling provided is not intended as a substitute for professional counseling.
- I understand that communication by text, phone or letter may be deemed necessary at the sole discretion of Phoenix Women's Clinic, and I hereby give permission for that contact to occur.
- I hereby give my full consent to receive medical services and waive and release any and all claims of any kind that I, my baby, my legal representatives, heirs and/or family members could have against Phoenix Women's Clinics, medical personnel, directors, officials, employees and volunteers. I expressly agree that this waiver and release of indemnity contract is intended to be as broad and inclusive as permitted by the laws of Arizona and also that if a portion of the same is held invalid, it is agreed that the remainder of the agreement shall continue in full force and legal effect.
- ***Privacy Notice:*** I understand that the staff of Phoenix Women's Clinic will have access to my confidential clinic records to provide for my medical care and for statistical purposes. My records will not be released to any agency or individual without my expressed permission, except as mandated by law. A patient copy of the Privacy Notice is available upon request.

I have read, understand, and agree with the above:

Patient Signature: _____ Date: _____ Print Name: _____

Witness: _____ Date: _____
Phoenix Women's Clinic Staff