



## Women's Health Care Specialists

### Gynecological Questionnaire

Patient Name: \_\_\_\_\_

GASTROINTESTINAL	YES	NO	NOTES
Weight Loss			
Weight Gain			
Fatigue			
<b>REPRODUCTIVE</b>			
Itching			
Vaginal Discharge			
Irregular Bleeding			
Heavy Periods			
Bleeding Between Periods			
Painful Periods			
Painful Intercourse			
Night sweats/hot flashes			
<b>BREAST</b>			
Pain in Breast			
Nipple Discharge			
Masses/lumps			
<b>CARDIO/PULMONARY</b>			
Irregular Heartbeat			
Chest Pain			
Wheezing			
Shortness of Breath			
Chronic Cough			
<b>GASTROINTESTINAL</b>			
Diarrhea			
Bloody or Black Stool			
Nausea/Vomiting			
Constipation			
Heartburn			
<b>URINARY</b>			
Blood in Urine			
Painful Urination			
Leakage of Urine			
Incomplete Emptying			

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<b>MUSCULOSKELETAL</b>			
Joint Swelling			
Chronic Pain			
<b>MENTAL HEALTH</b>			
Depression			
Crying Frequently			
Insomnia			
Anxiety			
<b>HEMATOLOGIC/LYMPHATIC</b>			
History of Blood Clots			
Bruises frequently			
Enlarged Lymph Nodes			
<b>SKIN</b>			
Worrisome Moles			
Rash			
<b>ALLERGIES</b>			
PLEASE LIST ANY ALLERGIES			

## Women's Health Care Specialists

### Consent for the Anti-HIV Blood Test

I have been informed that my blood will be tested in order to detect whether or not it contains antibodies to the human immunodeficiency virus (HN) which is the probable causation agent of acquired immune deficiency syndrome (AIDS). I understand the test is performed by drawing blood from my arm and processing the resulting specimen utilizing ELISA and Western Blot laboratory technology.

I have been informed that the ELISA test being utilized produces three (3) false positives (indicates presence of anti-HIV when it is not present) test results in every ten thousand (10,000) specimens processed, regardless of populations tested. I have also been informed that the test will be repeated, if positive, and a secondary level test (Western Blot) will be performed. The combination of these tests reduces the possibility of a false positive to a very small fraction per ten thousand (10,000) tests processed.

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I have been informed the ELISA test also fails to detect anti-HIV in rare instances and for a period immediately after infection with the virus. I have been offered re-testing if it is suspected that this has occurred.

I have been informed that if I have questions regarding the nature of the blood test, the expected benefits, the risks and alternative tests, I may ask questions before I decide to consent to the blood tests.

I have been informed that all positive HIV test results will be reported to the Health Department for partner notification. I have been informed that this reporting process does not require my consent and is mandated by law.

By my signature below, I acknowledge that I have been given all the information I have requested concerning this blood test. Therefore, I acknowledge that I have given consent for the performance of a blood test to detect antibodies to HN.

Patient Billing Consent: I further recognize that this testing will be filed for payment with my health insurance company.

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

Signature of Patient or Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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