THE WOMEN'S SPECIALIST
Established GYN Patient Questionnaire

Date:____________________ Name:____

Age:________ Date of birth:_____/_____/_____

Home Phone:( ) Work Phone:( ) Cell Phone:( )

Emergency Contact: ____________________ Relationship:____________ Phone:( )

Email address:______________________________@____________

Would you like to have lab results, appointment reminders, etc. emailed to you? If so, please check______

Current problem or reason for today's visit:

Past Medical History: *Have you ever had?*

High blood pressure	yes / no
Heart disease / heart attacks	yes / no
Lung disease / asthma	yes / no
Kidney disease	yes / no
Diabetes	yes / no
Clots in your legs (DVT) or lungs (PE)	yes / no
Gallbladder problems	yes / no
Cancer	yes / no
Thyroid problems	yes / no
Gastrointestinal problems	yes / no
Neurological problems (e.g.. seizure disorder)	yes / no
Psychiatric problems (e.g.. depression, anxiety)	yes / no
Eating disorder	yes / no
Migraine headaches	yes / no
Elevated cholesterol	yes / no
Bleeding disorders	yes / no

Other problems:____

Name of **primary care physician**, if any: ________________________________

Past surgical history: *(Please use back of sheet if more space is needed)* Check here if none ______

Ever had a colonoscopy? *Yes/no* *When?*______

Operation *Year* *Place*

Current medications: Check here if none ______

Please list all medications you are currently taking & how many times a day (include any herbal supplements)

Allergies: Check here if none ______

Please list all medications to which you are allergic to & your reaction to them

How many time have you been pregnant?_____ # of children living?_____

Vaginal deliveries?_____ cesarean sections?_____ abortions?_____ miscarriages?_____

First day of last period _____/_____/_____ Check here if you do not have periods ______

Bleed between periods? yes / no Bleed after sex? yes / no How long do they last? _____ days

Family history: Has anyone in your family ever had: (If yes, what relation & approximate age?)

__________Diabetes
__________Thyroid disease
__________Osteoporosis
__________Elevated Cholesterol
__________Other______________________________________

__________Mental illness / Depression
__________Heart Disease
__________High Blood Pressure
__________Clots in legs (DVT) or lungs (PE)

__________Breast Cancer
__________Uterine Cancer
__________Ovarian Cancer
__________Colon Cancer

Social Situation:

Marital Status: Married / separated / divorced / engaged / single / widowed / living with other
Occupation: ____
Race / ethnicity: _______________________
Religious Preference: _______________________
Do you drink alcohol? yes / no ________ X per week
Do you smoke? yes / no ________packs per day. How long?_______
Do you use other drugs? yes / no What?____
Do you wear your seat belt? yes / no
Do you exercise? yes / no

Have you ever been hit, slapped, kicked or otherwise physically hurt by someone? yes / no
Within the past 12 months? yes / no
Have you ever been forced to have sexual activities when you did not want to? yes / no
Within the past 12 months? yes / no

Review of Systems:

Have you had significant increase or decrease in your height? yes / no usual height__________
Have you had significant increase or decrease in your weight? yes / no usual weight__________

Do you have or have you had within last 12 months: (***Check the ones that pertain to you***)

_____Abnormal hair growth
_____Easy bruising or excessive bleeding
_____Hot flashes / flushes
_____Vaginal dryness
_____Vaginal discharge or irritation
_____Sleeping problems
_____Urine leaking when you cough or sneeze
_____Need to urinate 2 or more times per night
_____Burning with urination
_____Blood in your urine
_____Significant abdominal pain frequently
_____Frequent nausea and/or vomiting

_____The feeling that something is falling out of the vagina
_____Constipation or diarrhea
_____Blood in stool or dark and tar-like stools
_____Feeling sad and blue every day for the past 2 weeks
_____Breast lump(s)
_____Nipple discharge
_____Chest pain
_____Shortness of breath
_____Syncope (fainting spells)
_____Malaise and /or fatigue
Have you had a lifestyle change in the last year?
_____(loss of loved one, divorce, etc....)

Is there any other information I need to know in order to care for you?
(If so, please list below)

____
Patient Signature

______/______/______
Date

____
Provider (Doctor/NP) Signature

Sudheer Jayaprabhu, MD
Obstetrics & Gynecology

Kenneth West, MD
Obstetrics & Gynecology

Wadley Medical Plaza

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Phone: 903-792-1404 Fax: 903-792-2681

AUTHORIZATION TO LEAVE
PERSONAL HEALTH INFORMATION
BY ALTERNATE MEANS

Patient Name:___________________________________ DOB ____________________

Patient Mailing Address:____

____

__ May leave detailed message on telephone answering machine at home # __________

__ May leave detailed message on voicemail at work #____________________

__ May leave information with Spouse (Name) ____________________________

__ May leave information with other family member (Name)____________________

__ May leave detailed message on cellular phone # ________________________

__ May leave detailed message at a different location # ____________________

__ May send detailed message by email to:______________________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify The Women's Specialists should I change one or more of the telephone numbers listed above OR anyone of the contact names.

____ _______________
Patient or legally authorized individual signature Date

Please Print Name: ____

********PLEASE SEE NEXT PAGE *********

****MORE INFORMATION IS NEEDED ON NEXT PAGE ********

Sudheer Jayaprabhu, MD
Obstetrics & Gynecology

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AUTHORIZATION FOR
RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your privacy is important to The Women's Specialists. As a result, we ask you to complete the following authorization related to your personal health and health-related benefits.

I hereby authorize use and disclosure of protected health information (PHI), as described below.

Please PRINT all information legibly.

This Authorization related only to the PHI of:

NAME:______________________________ Last four digits of SS# _______________

I hereby authorize The Women's Specialists to release information about "My Account" at The Women's Specialists to the following people.

______________________________ ____________________________
Name Relationship to Patient

______________________________ ____________________________
Name Relationship to Patient

I hereby authorize The Women's Specialists to release information about my medical treatment (PHI) to the following people.

______________________________ ____________________________
Name Relationship to Patient

______________________________ ____________________________
Name Relationship to Patient

I have read and understand the following statements about my rights:

A. I may revoke this authorization at any time by giving written notice to The Women's Specialists. I understand that my revocation will not affect any use or the disclosure of my PHI that was made in reliance on the authorization before I revoked it.

B. My health provider cannot require me to sign this authorization in order to be eligible for services or treatment.

C. It is possible that the persons who receive information based on this authorization may disclose it to others and as a result the information may no longer be protected by federal privacy rules.

D. This Authorization for my personal health information does not apply to the release of the same information for any spouse or child that I may cover on my medical benefits or account at The Women's Specialists. I understand my spouse or child over 18 must provide Independent Authorization for release of their personal PHI.

I acknowledge that I received and signed a copy of this authorization.

SIGNATURE:______________________________________ DATE:_______________

THE WOMEN'S SPECIALIST

GENERAL CONSENT FOR TREATMENT

Patient Name: ______________________________ **Date of Birth:** ____/____/____

Patient Acct Number: ______________ **Insurer:** ______________________________

General Consent for Treatment

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include **routine diagnostic**, **radiology** and **laboratory procedures** and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment. This understanding includes that no research or experimental procedure may be done without my knowledge and consent.

Release of Medical Information

This form has been fully explained to me, and I understand its content and significance. I consent to The Women's Specialist's use of my health information related to the medical services provided for the following purposes: my treatment, obtaining payment for the medical services and for health care operations of The Women's Specialist or other treating providers, all as permitted under federal and state laws and regulations.

Payment

I assign and authorize payment, for any and all services rendered, directly to The Women's Specialist from my insurance company or third party payer including, but not limited to , Medicare, Medicaid, commercial health insurance, automobile no-fault insurance and workers disability compensation insurance.

In consideration of the health care services provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments and non-covered services.

Privacy Practices and Patient Rights and Responsibilities

The Women's Specialist's "Notice of Patient Privacy" provides information about how health information about patient may be used and disclosed. I, the patient, or his/her legal representative, acknowledges that I have been offered and opportunity to review the Notice before signing this form. I, the patient, or his/her legal representation, also acknowledges that I have received a copy of the "Patient Rights and Responsibilities" before signing this form.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

______________________________ ____/____/____

Signature of Patient Date of Signature

______________________________ ______________

Signature of Legal Representative (if patient unable to sign) Relationship to Patient