THE WOMEN'S SPECIALIST
New 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:

Menstrual History: *Check here if you do not have periods* _____

Are they regular every month? yes / no

How long do they last? _____ days

Are they..... heavy / normal / light

Are they painful? yes / no

Do you bleed between periods? yes / no

Do you bleed after sex? yes / no

First day of your last period _____/_____/_____

Gynecological exams:

Do you have yearly exams? yes / no

Ever had an *abnormal* Pap Smear? yes / no

Ever had..... cryo / laser / biopsy / none

Ever told you had..... fibroids of uterus / cysts / endometriosis / none

Do you perform regular self breast exams? yes / no

Last pap date _____/_____/_____ **Last mammogram** _____/_____/_____

Performed by: _____ **Where? WRMC / CSMH**

Infectious Disease: *Have you ever had any of the following?*

gonorrhea / chlamydia / herpes / warts / syphilis / tubal infection(PID) / trichomonas / HIV / AIDS / MRSA

Do you douche? yes / no

Contraception: *(Method of contraception you are currently using)*

None / Abstinence / Tubal ligation / Hysterectomy / Vasectomy / Norplant / Pills / Diaphragm / DepoProvera / IUD / Condoms / Natural family planning (rhythm) / Postmenopausal / Withdrawal / Other_____

Are you currently sexually active (within the past year)? yes / no

Pregnancies:

How many time have you been pregnant?_____

Deliveries: vaginal?_____ cesarean sections?_____

abortions?_____ miscarriages?_____ ectopic pregnancies?_____ molar pregnancies?_____

# of children living?_____

New GYN

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 cheolesterol	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)

Name of Medication	**Dosage (mg)**	**Frequency** How many times a day

Allergies: Check here if none_____

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

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

_____Diabetes	_____Mental illness / Depression	_____Breast Cancer
_____Thyroid disease	_____Heart Disease	_____Uterine Cancer
_____Osteoporosis	_____High Blood Pressure	_____Ovarian Cancer
_____Elevated Cholesterol	_____Clots in legs (DVT) or lungs (PE)	_____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	_____The feeling that something is falling out of the vagina
_____Easy bruising or excessive bleeding	_____Constipation or diarrhea
_____Hot flashes / flushes	_____Blood in stool or dark and tar-like stools
_____Vaginal dryness	_____Feeling sad and blue every day for the past 2 weeks
_____Vaginal discharge or irritation	_____Breast lump(s)
_____Sleeping problems	_____Nipple discharge
_____Urine leaking when you cough or sneeze	_____Chest pain
_____Need to urinate 2 or more times per night	_____Shortness of breath
_____Burning with urination	_____Syncope (fainting spells)
_____Blood in your urine	_____Malaise and /or fatigue
_____Significant abdominal pain frequently	Have you had a lifestyle change in the last year?
_____Frequent nausea and/or vomiting	_____ (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

The Women's Specialists

Sudheer Jayaprabhu, MD
Obstetrics & Gynecology

Kenneth West, MD
Obstetrics & Gynecology

Wadley Medical Plaza

1002 Texas Boulevard Suite 200 Texarkana, TX
Phone: 903-792-1404 Fax: 903-792-2651

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 ********

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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

PLEASE NOTE

ALL COPAYS, DEDUCTIBLES
&
CO-INSURANCES ARE DUE
WHEN SERVICES ARE RENDERED

MEDICARE PATIENTS WITH NO
SECONDARY INSURANCE WILL BE
RESPONSIBLE FOR DEDUCTIBLE AND
20% OF CHARGES AT TIME OF VISIT

If your insurance requires a referral, please obtain this before seeing the doctor or nurse practitioner. This is the patient's responsibility. If a referral is required and not obtained, the patient will be responsible for payment in full at the time of service. We require a copy of your insurance cared and driver's license at the time of service in order for you to be seen on an insurance basis. If you do not have a copy of your insurance card, you will be responsible for payment in full at the time of service.

If your Insurance Company uses a specific laboratory, please inform the physician or nurse upon having a biopsy, pap, or lab draw. Otherwise, the specimens will be sent to the lab at the discretion of the Physicians or the Nurse Practitioner.

If a biopsy or lab work is performed, you will receive a bill from the laboratory for these services.

THANK YOU

PLEASE INITIAL _____