THE WOMEN'S SPECIALIST
New OB 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______

Menstrual History:

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

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
___________Thyroid disease
___________Osteoporosis
___________Elevated Cholesterol
___________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....)

Genetics Screening:

Please check those that pertain to your family history and /or the baby's father's family history.

_____Down's syndrome
_____Cystic fibrosis
_____Jewish / French Canadian / Cajun descent
_____Huntington's chorea
_____Hemophilia
_____Thalassemia
_____Sickle cell disease or trait
_____Mental retardation
_____Spinal bifida / neural tube defects
_____Heart defects
_____Still births
_____Muscular dystrophy
_____Metabolic disorders
_____Any other inherited genetic or chromosomal problems?
____
____

Are you related to the father of the baby (other than marriage)? yes / no
If yes, what relation?_______________

Partner's Name:_________________________________ Partner's Phone #:(   )
Desired place of delivery:*(circle one)* Wadley Christus St. Michael Not decided yet
Desired Pediatrician:__________________________________ check if not decided yet_______

Obstetrical History:

Pregnancy	Date of Birth	M / F	Vaginal or C-section	Weight	Place	Complications
1						
2						
3						
4						
5						

Do you ever eat raw meat? yes / no
Do you have cats? yes / no
Do you eat soft cheeses?
(brie, camembert, bleu, etc....) yes / no

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

1002 Texas Boulevard Suite 200 Texarkana, TX
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

Kenneth West, MD
Obstetrics & Gynecology

Wadley Medical Plaza

1002 Texas Boulevard Suite 200 Texarkana, TX
Phone: 903-792-1404 Fax: 903-792-2681

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

WOMENS SPECIALISTS OF TEXARKANA

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE_______________________________

SECONDARY INSURANCE_____________________________

OTHER INSURANCE_________________________________

Does your insurance carrier exclude any type of coverage or service from your benefit coverage?______________________________

Please provide your insurance card(s) to our receptionists to make copies for our files. Thank you.

Patient Waiver of Medicaid Benefits

As The Womens Specialists of Texarkana has reached our quota for Medicaid patients, we are no longer accepting new Medicaid patients, either primarily or secondarily. If you currently have primary insurance coverage or are a self-pay patient, and during your medical care at this clinic you obtain Medicaid coverage, either primarily or secondarily, The Womens Specialists of Texarkana reserves the right to disregard your Medicaid coverage. Under these circumstances, we will not file your claims to Medicaid, nor will we honor any Medicaid correspondence concerning your account.

If you obtain Medicaid coverage and prefer to move your medical care to another provider, your medical records will be made available to your new physician.

I, __________________________, understand that The Womens Specialists of Texarkana is no longer accepting any new Medicaid patients. If, at any time during my medical care, I obtain Medicaid coverage, either primarily or secondarily, I understand that The Womens Specialists of Texarkana reserves the right to disregard my Medicaid coverage and will not file my medical claims to Medicaid. Any balances (deductibles and co-pays) not paid by my primary insurance carrier will be my responsibility to pay. If I'm a self-pay patient and I acquire Medicaid coverage, I understand that my claims will not be filed to Medicaid and I will remain a self-pay patient. If I drop my primary coverage and acquire Medicaid I understand that my claims will not be filed to Medicaid and I will become a self-pay patient.

______________________________ ______________________________

Date