

REGIONAL OBSTETRICS & GYNECOLOGY

Name:

Today's Date:

Date of Birth:

Age:

Reason for today's visit:

Please list any significant medical conditions for which you have been, or are currently being, treated:

- | | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Please list all previous surgical procedures:

- | | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Please list all of your medications, including dose and frequency:

- | | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Please list all drug allergies and include the reaction to each:

- 1.
- 2.
- 3.
- 4.

No known allergies

Past GYN History:

Age at first menses (period): _____

My periods are (choose one) _____regular _____mildly irregular
_____very irregular _____absent (i.e., menopause, hysterectomy, etc.)

My periods are:
_____not painful _____mildly painful _____extremely painful

My menstrual flow lasts _____ days on average and is: (circle one)
Normal very heavy

Have you had any abnormal PAP smears that required treatment?
Yes No If yes, what treatment? (i.e., cryosurgery,
LEEP procedure, cervical conization, etc.).

Have you ever been told that you had a sexually transmitted disease?
Yes No

If yes, circle all that apply:

Chlamydia	Genital herpes	Genital warts
Gonorrhea	PID	HIV
Trichomonas	Syphilis	Other_____

Do you desire STD (sexually transmitted disease) screening?
Yes No

Past OB History:

Have you ever been pregnant? Yes No

(If no, skip this section.)

Total number of pregnancies: _____

Total number of live births: _____

Total number of miscarriages: _____

Total number of abortions: _____

Have you ever had a tubal pregnancy? Yes No

For each pregnancy, list the following details:

<u>Date</u>	<u>Sex</u>	<u>Weight</u>	<u>C/S or Vaginal</u>	<u>Complications of Preg. or Delivery</u>
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Social History

Married or single? _____

Your occupation: _____

Spouse's occupation: _____

Do you drink alcohol? **Yes** **No**
 If yes, how much? **Rarely** **Social** **Daily**

Do you smoke tobacco? **Yes** **No**

Do you use marijuana or other street drugs? **Yes** **No**
 If so, what?

Family History (parents, grandparents, siblings, children)

If any of the following disorders are found in the above family members, please circle yes or no and list the affected family members.

Breast cancer:	Yes	No
Ovarian cancer:	Yes	No
Uterine cancer:	Yes	No
Cervical cancer:	Yes	No
Colon cancer:	Yes	No
Mental retardation:	Yes	No
Birth defects:	Yes	No
Blood clotting disorders	Yes	No
(DVT, "free bleeder", etc.)		

Dr. Stewart and Dr. Jones specialize in Obstetrics & Gynecology and will provide care related to this field of medicine only. They strongly advise each patient to have a primary care doctor such as a Family Practitioner or Internist for general medical care. Please list the name of your primary care doctor below. If you do not have one, Dr. Stewart and Dr. Jones will be happy to make a recommendation.

My primary care physician is: _____

PATIENT/INSURANCE INFORMATION**DATE:**

Patient Name:		Home Phone:
Address:		Work Phone:
City/State/Zip:		Cell Phone:
Employer/School:		E-Mail Address:
Sex:	Age:	Date of Birth:
Marital Status:		Social Security #:
Emergency Contact:	Relationship:	Phone #:

Whom may we thank for referring you?

INSURANCE INFORMATION

Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance Group #	Insurance ID#	Insurance Group #:	Insurance ID#:
Insured Name:		Insured Name:	
Address (If different from patient's):		Address (If different from patient's):	
City/State/Zip:		City/State/Zip:	
Insured DOB:	Insured SS#:	Insured DOB:	Insured SS#:

Financial Responsibility, Assignment of Insurance Benefits

I certify that I, and/or my dependent(s), have insurance coverage with _____
 Name of insurance company(ies)

and assign directly to Regional Obstetrics & Gynecology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of patient or authorized person: _____ Date: _____

Consent for Release of Medical Information

Regional Obstetrics & Gynecology may use my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company);
- The day-to-day healthcare operations of your practice

I understand that I have the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under the Health Insurance Portability and Accountability of 1996 (HIPAA).

Signature of patient or authorized person: _____ Date: _____

I wish to be contacted in the following manner (check all that apply):

_____ Home Telephone # _____ _____ Ok to leave detailed message _____ Leave message with call-back number only	_____ Work Telephone # _____ _____ Ok to leave detailed message _____ Leave message with call-back number only
_____ Cell Phone # _____ _____ Ok to leave detailed message _____ Leave message with call-back number only	_____ Written Communication _____ Ok to mail to my home address _____ Ok to mail to my work/office _____ Ok to FAX to # _____

Signature of patient or authorized person: _____ Date: _____

REGIONAL OBSTETRICS & GYNECOLOGY

CONSENT TO ROUTINE PROCEDURES & TREATMENTS

Important: Do not sign this form without reading and understanding its contents. Mark out and initial any procedure and/or section of this form for which consent is not granted.

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures may be necessary. These procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals.

While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures. I also understand that various healthcare professionals may have differing opinions as to what constitutes material risks and alternative procedures.

If I have any questions or concerns regarding these procedures, I will ask my physician to provide me with additional information. The procedures may include the following:

1. **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (Ivs). The material risks associated with these types of procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb, paralysis or partial paralysis or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
2. **Physical tests, Assessments and Treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, respiratory therapy, physical therapy, and other similar procedures. The material risks associated with these types of procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, worsening of the condition and death. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.
3. **Administration of Medications** whether orally, rectally, topically or through my eye, ear or nose. The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
4. **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
5. **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

I understand that:

- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any procedures.
- The healthcare professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions.
- **Physicians may ask me to sign additional required Informed Consent documents for specific procedures and tests.**

By signing this form:

- I consent to healthcare professionals performing procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, **including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained.**
- I acknowledge that I have been informed in general terms of the nature and purpose of the procedures, the material risks of the procedures, and practical alternatives to the procedures.

Witness

Date: _____

Person giving consent

Relationship to patient if not the patient: _____

Patient unable to sign because of: _____

Physician