Welcome to Amber Health Care for Women

www.AmberHealthCareforWomen.com

Our office is currently accepting a limited number of new patients. We are seeing patients for annual exams, treatment of abnormal pap smears, birth control, low-risk pregnancy, vaginal rejuvenation, endometrial ablation, and many gynecologic conditions such as menopause and heavy periods.

Please complete all the forms in the new patient packet and mail, fax, or bring them to the office, along with a copy of your insurance card (front and back). Our office will review them and call you to schedule an appointment. Please refer to our website to see if we are a provider on your medical insurance plan. We are not accepting Medicare, Medical, or PHP.

1) What do you need to be seen for?: _____

_____

2) Have you been treated for this problem in the past? If yes, what doctor, when, and how?
Have you had any gynecologic surgeries? If yes, what doctor, when, and what surgery?
If yes, please download a release of medical records form and fax it / mail it to your old doctor.

_____

_____

_____

3) Have you been seen in our office in the past? If yes, what year / under what name?

_____

4) What is your Height: _____ Weight: _____ Birth Control Method: _____

5) Are you planning to get pregnant? _____

6) When was your last pap smear and was it normal? _____

****

PLEASE NOTE THAT THERE ARE SOME CONDITIONS THAT OUR OFFICE DOES NOT TREAT.

Our office does NOT provide care for pediatric patients (under the age of 16).

For pregnancy: Our office does NOT perform abortions, treat infertility, provide care for midwife patients, perform VBACs, or provide prenatal care for very high-risk patients, including: Patients with pre-pregnancy diabetes, seizure disorder, chronic high blood pressure, lupus, severe obesity, large fibroids, triplet pregnancy, or patients taking chronic blood thinners, suboxone, methadone, marijuana or other illicit drugs.

For gynecology: Our office does NOT treat cancer, bladder or rectal incontinence, interstitial cystitis, vaginal mesh erosions, vulvodynia / vestibular vulvitis, desquamative vaginitis, severe endometriosis, perform surgery on high-risk patients, or do pessary care, Essure coil placement / removal, or sexual assault / rape exams.

Our office is NOT a primary care office or walk-in clinic. We do NOT provide care for chronic medical conditions (such as asthma, diabetes, thyroid disease, hemorrhoids) or for acute medical conditions (such as kidney stones, rashes, flu). We do NOT perform COVID19 testing.

Our office does NOT provide emergency care services or offer same-day appointments.

1842 Buenaventura Blvd. Redding CA 96001 * Phone: 530-225-8500 * Fax: 530-246-4000

PERSONAL MEDICAL AND SURGICAL HISTORY

Yes / No Have YOU ever had the following?

- ❑ ❑ hyperthyroid (high)
- ❑ ❑ hypothyroid (low)
- ❑ ❑ diabetes
- ❑ ❑ glaucoma
- ❑ ❑ bladder interstitial cystitis
- ❑ ❑ frequent bladder infections
- ❑ ❑ kidney infections
- ❑ ❑ kidney stones
- ❑ ❑ kidney failure
- ❑ ❑ migraine headaches
- ❑ ❑ anemia
- ❑ ❑ varicose veins or superficial thrombophlebitis
- ❑ ❑ deep venous thrombosus (DVT) - blood clots in legs
- ❑ ❑ pulmonary embolus (PE) - blood clots in lungs
- ❑ ❑ systemic lupus erythematosus (SLE)
- ❑ ❑ anti-phospholipid antibody syndrome
- ❑ ❑ seizures / epilepsy
- ❑ ❑ arthritis
- ❑ ❑ asthma
- ❑ ❑ COPD
- ❑ ❑ sleep apnea
- ❑ ❑ gastric bypass surgery
- ❑ ❑ gastric reflux / GERD
- ❑ ❑ hiatal hernia
- ❑ ❑ liver cirrhosis
- ❑ ❑ gallstones
- ❑ ❑ irritable bowel disease
- ❑ ❑ ulcers (stomach or intestines)
- ❑ ❑ Crohn's disease or ulcerative colitis
- ❑ ❑ diverticulosis or diverticulitis
- ❑ ❑ eating disorder: anorexia or bulimia
- ❑ ❑ alcoholism or drug abuse
- ❑ ❑ clinical depression
- ❑ ❑ anxiety disorder, panic attacks, or bipolar disorder
- ❑ ❑ osteopenia or osteoporosis
- ❑ ❑ mitral valve prolapse or other valvular disease
- ❑ ❑ coronary artery disease or heart attack
- ❑ ❑ high cholesterol
- ❑ ❑ high blood presure / hypertension
- ❑ ❑ stroke
- ❑ ❑ skin disease: psoriasis or eczema
- ❑ ❑ skin disease: lichen sclerosus
- ❑ ❑ fibrocystic breast disease / dense breasts
- ❑ ❑ breast cancer
- ❑ ❑ ovarian cancer
- ❑ ❑ colon cancer
- ❑ ❑ other cancer
- ❑ ❑ infertility
- ❑ ❑ uterine fibroids
- ❑ ❑ endometriosis
- ❑ ❑ polycystic ovarian syndrome (PCOS)
- ❑ ❑ abnormal pap smear (how treated?)
- ❑ ❑ other chronic or serious illness:
- ❑ ❑ Have you ever been sexually abused or raped?
- ❑ ❑ Have you ever had a blood transfusion?
- ❑ ❑ Have you ever gastric bypass surgery?
- ❑ ❑ Are you a Jehovas Witness who refuses blood products?

INFECTIOUS DISEASE HISTORY Have YOU ever had:

Yes / No

- ❑ ❑ chicken pox
- ❑ ❑ shingles
- ❑ ❑ COVID
- ❑ ❑ tuberculosis (TB)
- ❑ ❑ rheumatic fever / german measles
- ❑ ❑ measles, mumps, rubella, polio, malaria, or yellow fever
- ❑ ❑ Have you been vaccinated for ❑ HPV / ❑ HepB / ❑ TB?
- ❑ ❑ STDs : ❑ Gonorrhea ❑ Chlamydia ❑ PID
  ❑ HIV / AIDS ❑ Trichomonas ❑ syphilis
  ❑ Herpes ❑ genital warts ❑ HPV on pap smear

Yes / No

- ❑ ❑ scarlet fever
- ❑ ❑ hepatitis
- ❑ ❑ positive PPD test
- ❑ ❑ MRSA skin infection

FAMILY HISTORY If yes, which relative and age when diagnosed?

Yes / No

- ❑ ❑ DVT or PE (blood clots in the legs or lungs)
- ❑ ❑ stroke or heart attack before age 60
- ❑ ❑ diabetes
- ❑ ❑ high cholesterol
- ❑ ❑ high blood pressure
- ❑ ❑ osteoporosis
- ❑ ❑ breast cancer
- ❑ ❑ ovarian cancer
- ❑ ❑ colon cancer
- ❑ ❑ other cancer

GENETIC HISTORY Do you or your family have any of the following?

Yes / No

- ❑ ❑ Factor 5 Leiden mutation or other "clotting" diseases
- ❑ ❑ Factor 8 vonWillebrand deficiency or "bleeding" diseases
- ❑ ❑ Alpha or Beta thalassemia or sickle cell trait or disease
- ❑ ❑ Huntington chorea
- ❑ ❑ muscular dystrophy

PREGNANCY HISTORY

____ total number of pregnancies
____ full term births (after 37 wks)
____ preterm birth (before 37 wks)
____ tubal / ectopic pregnancies

____ miscarriages
____ stillbirth
____ abortions
____ living children

Date of birth	Term or preterm?	vaginal or cesarean?	Baby's sex	Baby's weight	Complications?

Yes / No **SURGERY HISTORY** If yes, what surgery and what year?

❑ ❑ Have you had any surgeries?

Date: _____ Name: _____ DOB: _____

REVIEW OF SYSTEMS ** Please fill in every box and answer every question. ** Updated 2024

Please inform the front office if there have been any changes to your address, phone numbers, insurance, employment, or marital status.

What is the reason for your visit?

❑ Yes / ❑ No Do you have an Advanced Health Care Directive (AHCD)? If not, would you like information on AHCD? ❑ Yes / ❑ No

1) CONSTITUTIONAL
- ❑ fever ❑ none
- ❑ weight loss
- ❑ weight gain
- ❑ fatigue
- ❑ sleep problems
- ❑ loss of appetite

2) PSYCHIATRIC
- ❑ severe depression ❑ none
- ❑ severe anxiety

3) EYES
- ❑ visual problems ❑ none

4) NEUROLOGIC
- ❑ headache ❑ none
- ❑ seizures
- ❑ fainting or dizziness
- ❑ memory loss
- ❑ trouble walking
- ❑ numbness

What pharmacy do you use?

5) ALLERGIC
- ❑ latex allergy ❑ none
- ❑ betadine allergy
- ❑ sinus drainage
- ❑ sneezing
- ❑ hay fever
- ❑ hives / swelling

6) ENDOCRINE
- ❑ heat intolerance ❑ none
- ❑ cold intolerance
- ❑ excessive hair loss
- ❑ excessive hair growth

7) BREASTS - SKIN
- ❑ breast pain ❑ none
- ❑ breast lumps
- ❑ breast discharge
- ❑ dry or scaly skin
- ❑ rashes / itching
- ❑ skin ulcers or lesions
- ❑ acne

8) MUSCULOSKELETAL
- ❑ joint pain ❑ none
- ❑ muscle weakness

9) EARS - NOSE - THROAT
- ❑ ear pain ❑ none
- ❑ hearing loss
- ❑ ringing in your ears
- ❑ sore throat
- ❑ nose bleeds
- ❑ cold sores

10) HEME - LYMPHATIC
- ❑ bruising easily ❑ none
- ❑ bleeding easily
- ❑ painful varicose veins
- ❑ swollen glands / lymph nodes

11) CARDIOVASCULAR
- ❑ chest pain ❑ none
- ❑ palpitations
- ❑ leg swelling
- ❑ need to sleep propped up
- ❑ short of breath with activity

12) RESPIRATORY
- ❑ wheezing ❑ none
- ❑ cough
- ❑ coughing blood
- ❑ shortness of breath
- ❑ painful breathing

13) GASTROINTESTINAL
- ❑ bloating / gas ❑ none
- ❑ diarrhea
- ❑ constipation
- ❑ abdominal pain
- ❑ bloody stool or black stool
- ❑ indigestion / reflux
- ❑ nausea / vomitting
- ❑ jaundice (yellow skin)

14) GU - URINARY
- ❑ bloody urine ❑ none
- ❑ frequent urination
- ❑ urgent urination
- ❑ painful urination
- ❑ incomplete bladder emptying
- ❑ incontinence of urine

GU - GYNECOLOGY
- ❑ pelvic pain ❑ none
- ❑ low libido (sex drive)
- ❑ vaginal itching
- ❑ vaginal discharge
- ❑ vaginal odor
- ❑ abnormal bleeding

PMS: occuring every month, but only 1-2 weeks before your period
- ❑ anxiety ❑ none
- ❑ depression
- ❑ irritability / anger
- ❑ social withdrawal
- ❑ headache
- ❑ breast pain
- ❑ bloating or swelling

Menopause symptoms
- ❑ mood swings ❑ none
- ❑ hot flashes or night sweats
- ❑ vaginal dryness

Birth Control Method (current)
- ❑ tubes tied ❑ none
- ❑ vasectomy
- ❑ withdrawal (“pulling out”)
- ❑ rhythm / natural family planning
- ❑ condoms
- ❑ IUD
- ❑ DepoProvera injections
- ❑ vaginal ring
- ❑ birth control patch
- ❑ birth control pills
- ❑ Nexplanon rod (arm insert)

When was your last period? _____ *If having periods:*

How often do you have a period? _____

How many days do your periods last? _____

Describe your bleeding: ❑ light ❑ moderate ❑ heavy

Describe your mentrual cramps: ❑ mild ❑ moderate ❑ severe

Yes / No
- ❑ / ❑ Do you ever skip periods?
- ❑ / ❑ Do you have bleeding in between your periods?
- ❑ / ❑ Do you soak through to your clothes?
- ❑ / ❑ Do you pass blood clots? How large? _____
- ❑ / ❑ Do your periods limit your activities?

Yes / No
- ❑ / ❑ Are you currently breast feeding?
- ❑ / ❑ Do you do self breast exams? If yes, how often? _____
- ❑ / ❑ Are you sexually active? *If sexually active:*
- ❑ / ❑ Do you have pain with sex?
- ❑ / ❑ Do you have bleeding with sex?
- ❑ / ❑ Do you use condoms?
- ❑ / ❑ Do you currently have more than one sexual partner?

Are your sexual partners: ❑ male ❑ female ❑ both

Yes / No
- ❑ / ❑ Would you like to be tested for sexually transmitted diseases?
- ❑ / ❑ Do you feel UNSAFE where you live?
- ❑ / ❑ In the past year, have you felt the urge to physically hurt yourself or committ suicide?
- ❑ / ❑ In the last year, have you been threatened, slapped, hit, kicked or forced to perform sexual acts without your consent?

SOCIAL HISTORY

What is your current job?

What is your current maritial status?

Yes / No If yes, how much / how often?
- ❑ / ❑ exercise?
- ❑ / ❑ caffeine? (colas / coffee / tea)
- ❑ / ❑ alcohol?
- ❑ / ❑ tobacco / vaping?
- ❑ / ❑ marijuana?
- ❑ / ❑ street drugs?

Yes / No For Returning Patients: (If yes, please detail)
- ❑ / ❑ Have you developed any new medical conditions?
- ❑ / ❑ Have you had any surgeries, serious illness, or injuries?

ALLERGIES: ❑ Yes / ❑ No Are you allergic to any medicines, any foods, latex, adhesive tape, or x-ray dye? If yes please detail.

MEDICATIONS

Yes / No If yes, how much / how often?
- ❑ / ❑ Do you take any prescription and over-the-counter medicines?
- ❑ / ❑ Do you take other herbs or supplements?
- ❑ / ❑ Do you take calcium or other vitamins?

Date: _____ Name: _____ DOB: _____

MEDICAL RECOMMENDATIONS

Annual physical exams – Every woman should have a full physical exam once a year, to do a physical exam, review your health, family history, medications, risks, and recommended screening tests. An OB-GYN specialist treats issues such as birth control, pregnancy, PMS, menopause, and heavy or painful periods. If a woman has medical or psychiatric problems, she should also be under the care of an internist, family practice doctor, and/or psychiatrist.

Pap smears – A pap smear looks for cervical cancer and pre-cancer (called dysplasia). In many parts of the world, cervical cancer is the # 1 cancer, but it is rare in the US because of screening with pap smears. Symptoms of cervical cancer include pain, discharge, and bleeding after sex. Pre-cancer may have no symptoms. There are different opinions about how often a woman should have a pap smear. We recommend a yearly pap smear for most women ages 21-64.

Mammograms – Breast cancer and lung cancer are tied for # 1 cancer in women in the US -- The lifetime risk of developing breast cancer is 12% (1 in 8). A mammogram looks for breast cancer – specifically, for "early detection", to catch it when it is very small, which makes it easier to treat. We recommend a yearly mammogram for women age 40 and older.

Colonoscopy – Colon cancer is the #2 cause of cancer (and cancer deaths) in women in the US -- The lifetime risk of developing colon cancer is 5% (1 in 20). A colonoscopy looks for colon cancer and precancerous colon polyps. A slim, long fiber-optic camera is inserted into the rectum to look at the inside of the colon (the large intestine). Symptoms of colon cancer include constipation, pain, and rectal bleeding, but some cancers have no symptoms at early stages. Some women choose to screen with a home-collected stool specimen every 3 years, starting at age 45. We recommend a screening colonoscopy, every 10 years, starting at the age of 50.

Dexascan – A Dexascan is a special x-ray of the spine and hips that looks for osteoporosis (a dangerous thinning of the bones). Osteoporosis is a "silent" disease, with no symptoms until it reaches causes a hunched back or broken bones. A Dexascan should be done periodically in all post-menopausal women, starting at age 65 and earlier in patients with risk factors.

STD testing and condom use – Abstinence from sex is the best way to prevent catching and spreading STDs (sexually transmitted diseases), such as HIV, herpes, genital warts, syphilis, Chlamydia, gonorrhea and hepatitis. Some STDs (like HIV and hepatitis) can also be spread by blood (from transfusions, needle sticks or IV drug abuse). Using a condom during sex lowers the risk of catching an STD. Ask for an STD check if you would like to be tested.

Smoking –Lung cancer is tied with breast cancer for the tied for # 1 cancer in women in the US and is the # 1 cause of cancer deaths. Smoking kills people. Smoking also causes heart attacks and strokes (the # 1 cause of death in the US), lung damage (emphysema and COPD), and many cancers, including mouth, throat, tongue, lung, stomach, kidney, bladder, breast and cervix. Smoking in pregnancy can cause miscarriage, preterm labor, a growth-retarded baby, and stillbirth from placental abruption. Smoking around kids causes SIDS (crib death) and asthma. Do not smoke. If you smoke, ask your doctor to help you quit.

I have read the above and understood the recommendations underlined.

Patient Signature:_____Date:_____

Date: _____ Patient Name: _____DOB:_____

Acknowledgement of Receipt of Notice of Privacy Practices and
Authorization to Disclose Health Information and / or Leave Electronic Messages

Under the Patient Privacy Act, the use and disclosure of a patient's private health information is limited to strictly defined situations. These are explained in our NOTICE OF PRIVACY PRACTICES, which is available for review or copy in our waiting room, and available for download from our practice website. I hereby acknowledge that I have been given the opportunity to read the Notice of Privacy Practices.

Patient signature: _____ Date: _____

Please note: It is our general office policy to notify our patients by phone for:

1) for all biopsy results (normal or abnormal)
2) for CT scans, MRIs, ultrasounds (normal or abnormal)
3) for abnormal pap smears, abnormal labs, and abnormal mammograms
4) for results that necessitate further testing or treatment
5) for lab problems that necessitate repeat testing (such as an inadequate specimen)

For normal pap smears, normal lab tests, normal mammograms, patients can access their test results by creating a patient portal with the facility that performed the test (MD Imaging, North Valley Breast Clinic, LabCorp, Quest Labs). Our pap smears are sent to Quest Laboratories (2024).

Our office cannot disclose a patient's private health information to ANYONE other than the patient, except as explained in the Notice of Privacy Practices, without the patient's written permission.

Please indicate **if you would like us to be able to speak to your family members or spouse**.

❑ I authorize Amber Health Care for Women to release any information regarding my healthcare (including test results and appointment information) to the following person(s).

Name: _____ Relationship: _____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

-OR

❑ I **DO NOT WISH** Amber Health Care for Women to release any information regarding my healthcare (including test results and appointment information) to any individual other than myself.

Patient signature: _____Date: _____

❑ I authorize Amber Health Care for Women to leave electronic messages regarding test results on my answering machine or my voicemail. We cannot guarantee that such information will not be inadvertently overheard by others.

-OR

❑ I **DO NOT WISH** Amber Health Care for Women to leave any messages regarding test results on my answering machine or my voicemail.

Patient signature:_____Date: _____

Date:_____ Patient Name: _____ DOB: _____

PATIENT DEMOGRAPHIC INFORMATION (UPDATED 3/2024)

Please provide your current insurance card and your driver's license to the receptionist to photocopy. Please inform us at every visit if there have been updates to your insurace or demographic information. Forms and office policies are available for download at Amberhealthcareforwomen.com

Patient Full Name: _____
Last First Middle Maiden Name

Date of Birth: _____ Social Security Number: _____

Mailing: _____
Address P.O/Box/Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Preferred phone number for us to call: ❑ Home ❑ Work ❑ Cell

Primary Care Physician: _____

Preferred Pharmacy: _____

Employer/Occupation: _____ Primary Language: _____

Maritial Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Name of Spouse: _____ Birthdate: _____ Cell Phone: _____

Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

Nearest relative not living with you: _____ Relationship: _____ Phone No: _____

How did you hear about our practice? ❑ Website ❑ Word of Mouth ❑ Doctor referral ❑ Other:
❑ Insurance Provider List ❑ Practice Brochure ❑ Magazine Ad ❑ Dignity Physician Referral Line ❑ Facebook

Person responsible for this account: ❑ Self ❑ Other: _____

Primary Insurance Company: _____

Policy Holder's Name: _____ Policy Number: _____

Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____

❑ Yes ❑ No Do you have a secondary insurance? Secondary Insurance Company: _____

Policy Holder's Name: _____ Policy Number: _____

FINANCIAL POLICIES AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all charges for services rendered. I understand that Dr. Cheryl Serr / Amber Health Care for Women will bill my insurance plan and bill me for any remaining balance - such as charges applied towards my decuctible or co-pays, and for services not covered by my insurance plan. I hereby give lifetime authorization for payment of insurance or Medicare benefits to be directly to Dr. Serr for services rendered. I understand and agree to abide by the following practice policies: Co-payments are due at time of service; deliquent balances that remain unpaid beyond 30 days may be assigned late-fee service charge (not to exceed the maximum rate permissible by law); delinquent balances that remain unpaid beyond 90 days will be assigned to a collections agency; patients who are assigned to collections will be dismissed from the practice; **the practice reserves the right to charge up to a $150 fee to patients who "no-show" to appointments or cancel with less than 24 hours notice**. In the event of default, I agree to pay all costs of collection and resonable attorney's fees. I further agree that a photocaopy of this agreement shall be as valid as the original.

Date: _____ Patient / Parent or Guardian Signature: _____

Date: _____ Name: _____ DOB: _____