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.

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

4) Are you currently planning / trying to get pregnant? _____

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, chronic vaginitis / 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. We do NOT provide emergency care services or offer same-day appointments.

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

PATIENT DEMOGRAPHIC INFORMATION (UPDATED 9/2023)

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: _____

Address _____
Street City State Zip Code

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: _____

Pregnancy Questionnaire - If you are currently pregnant please answer the following questions:

NAME _____ DOB:_____ Age:_____ Date: _____
LAST FIRST

What is your height?_____What is your weight? _____ What did you weigh before you got pregnant? _____
When was your last pap smear? _____ Was it normal? _____
When did you first have a positive pregnancy test? _____
What was the first day of your last period?_____ ❑ sure ❑ approximate ❑ unknown
Was your last period normal amount and duration? ❑ Yes ❑ No

If you answer yes, how much?	Yes / No	before pregnancy	Yes / No	during pregnancy
Do you drink alcohol?	❑ ❑	_____	❑ ❑	_____
Do you smoke? (tobacco or cigars)	❑ ❑	_____	❑ ❑	_____
Do you use marijuana?	❑ ❑	_____	❑ ❑	_____
Do you use street drugs (what type)?	❑ ❑	_____	❑ ❑	_____
Do you use methadone / suboxone?	❑ ❑	_____	❑ ❑	_____

Have you, the baby's father, any of your children, or anyone in either of your families ever had any of the following?

You	Baby's father		You	Baby's father	
Yes / No	Yes / No		Yes / No	Yes / No	
❑ ❑	❑ ❑	heart defects at birth	❑ ❑	❑ ❑	Tay-Sachs carrier or disease
❑ ❑	❑ ❑	cleft lip or palate	❑ ❑	❑ ❑	sickle cell trait or disease
❑ ❑	❑ ❑	other birth defects	❑ ❑	❑ ❑	alpha or beta thalassemia
❑ ❑	❑ ❑	mental retardation	❑ ❑	❑ ❑	cystic fibrosis carrier or disease
❑ ❑	❑ ❑	Down syndrome (mongolism)	❑ ❑	❑ ❑	PKU
❑ ❑	❑ ❑	other chromosome abnormalities	❑ ❑	❑ ❑	polycystic kidney disease
❑ ❑	❑ ❑	hydrocephaly ("water brain")	❑ ❑	❑ ❑	a baby die from SIDS (crib death)
❑ ❑	❑ ❑	neural tube defect / spina bifida ("open spine"), meningomyelocele, or anencephaly (no brain)			

If yes, please give details: _____
Certain diseases are more common in people of certain ethnic and racial groups.
What is your ethnic/racial family background? _____
What is the baby's father's family background? _____
(white/Caucasian, black/African American, Asian, Hispanic, Mediterranean, Italian, Greek, Cajun, Jewish, French-Canadian.)

Yes / No Have you or the father of the baby had any of the following:
❑ ❑ Any history of sexually transmitted diseases (Gonorrhea, Chlamydia, Syphilis, Herpes, genital warts, HIV or AIDS).

Yes / No If you answer yes to any of the following questions please give details in the space below.
❑ ❑ Were you taking birth control when you got pregnant or just before?
❑ ❑ Did you receive any infertility treatments to become pregnant? If yes, what?
❑ ❑ Have you ever had a stillborn child or child that died shortly after birth?
❑ ❑ Have you had three or more miscarriages?
❑ ❑ Since you became pregnant, have you had any vaginal bleeding (more than just spotting)?
❑ ❑ Since you became pregnant, have you been exposed to any radiation, x-rays, or hazardous chemicals?
❑ ❑ Since you became pregnant, have you been sick with a rash or high fever?
❑ ❑ Do you live with anyone with a contagious disease (TB, HIV, Hepatitis, Herpes)?
❑ ❑ Since you became pregnant, have you taken prescription or over-the-counter drugs, mega-vitamins, or herbs?
If yes, please list:

If you have been pregnant before, did you have any of the following complications?

❑ incompetent cervix	❑ pre-eclampsia / PIH	❑ none
❑ preterm labor	❑ placenta previa	❑ gestational diabetes
❑ IUGR (growth restriction)	❑ Rh isoimmunization	❑ placental abruption
❑ problems during labor		❑ shoulder dystocia

For office use: calculate BMI_____ calculate EDD_____ accepted: ❑ Yes ❑ No

PREGNANCY POLICIES AND FREQUENTLY ASKED QUESTIONS

WEBSITE
Our office website: amberhealthcareforwomen.org and amberhealthcareforwomen.com has a pregnancy page filled with information about pregnancy and answers to your most common pregnancy questions.

HOSPITAL AND CALL GROUP
Dr. Serr shares after-hours call with other OB doctors in the community (both male and female). Any of these doctors may be present for your delivery. Deliveries at Mercy Hospital in Redding (not at Saint Elizabeth's in Red Bluff or Mercy Mount Shasta). Dr. Serr does not co-manage pregnancy with midwives or do "home births". The hospital does not allow "VBACs" (vaginal delivery after a prior caesarean section).

OFFICE VISITS and VIDEO POLICY
Your visits to our office will be divided between Dr. Serr and one of our specialized nurse practitioners.
Video-tapping is not allowed during your delivery or during office ultrasounds/visits.

BILLING POLICY
You are responsible for any medical bills that are not paid by your insurance. Our office will collect an "OB deposit" of $300 at your 1st visit, and more in your third trimester (depending upon your insurance benefits). Please refer to our website "Cost of Pregnancy Care" page for details.

DRUG TESTING POLICY
Drug and alcohol use and addiction are very serious conditions that place an unborn child at high risk for birth defects, miscarriage, stillbirth, and other complications of pregnancy. Our office will perform random drug testing on all patient and will dismiss patients who test positive. Our office does NOT accept patients who take "medical marijuana" during pregnancy, or patients on methadone / suboxone.

VERY HIGH RISK OBSTETRICS POLICY
Our office is not currently accepting very high risk obstetrical patients. This includes patients with Rh isoimmunization, auto-immune diseases, Type I diabetes, poorly controlled high blood pressure, seizure disorders / epilepsy, a high body mass index, and certain other medical conditions. Please ask the office if you are unsure if you would be considered very high risk. Having had a caesarean section does <u>not</u> make a patient very high risk.

GENETIC TESTING IN PREGNANCY
Some genetic diseases are more common to people of certain race, ethnicity of family backgrounds. Please refer to the following sheet for details. We recommend testing (and possible referral to a genetic counsellor or perinatologist) for families with a history of genetic diseases, certain backgrounds, and especially those of Ashkenazi-Jewish descent

I understand and agree to abide by all of the above policies.

Date: _____Name: _____ DOB: _____ Signature: _____

HIV TESTING CONSENT

It is recommended, and required by law, that all pregnant women be offered a blood test for HIV / AIDS. HIV is transmitted by contact with HIV infected blood or bodily fluids (semen, saliva, breast milk), or to a child during pregnancy and delivery. A person can be HIV positive and have no symptoms. You are considered at high risk to have been exposed to HIV / AIDS if you have received a blood transfusion, used IV drugs, had multiple sexual partners, or had sex with a gay or bisexual man, or a man who ever used IV drugs, or a man with HIV / AIDS. **If you are HIV positive, there are medicines you can take that will drastically lower the risk of passing HIV to your unborn child. Our office strongly recommends HIV / AIDS testing, even if you have tested negative in the past.**

□ I wish to have HIV / AIDS testing. (signature and date) _____

OR □ I decline HIV / AIDS testing. (signature and date) _____

GENETIC DISEASE TESTING CONSENTS

- "Genetic diseases" are illnesses that are inherited from parent to child, and hence "run in families".
- You can be a "carrier" for a genetic disease without having symptoms.
- If two "genetic carriers" have a child together, the child may then have the disease.
- If you have already been tested for a genetic disease you never need to be tested again. The results will not change.
- Genetic testing is very expensive and may not be covered by your insurance as a part of "routine pregnancy tests" .
- If both parents test positive for a genetic disease, the fetus can be tested with amniocentesis or CVS.

CYSTIC FIBROSIS TESTING

Cystic fibrosis is a genetic disease which causes severe lung and intestinal disease, and death. A person can be a "carrier" of the cystic fibrosis gene and have no symptoms. The risk of being a carrier is about 1/700. If *both parents* are carriers, the baby has a 25% chance to have cystic fibrosis. The risk of cystic fibrosis is higher in Caucasian (White), French Canadian, and Eastern European Jewish backgrounds.

□ I wish to have cystic fibrosis testing. (signature and date) _____

OR □ I decline cystic fibrosis testing. (signature and date) _____

SICKLE CELL DISEASE

Sickle cell disease is a genetic disease which causes severe anemia, stillbirth, stroke, heart attack, death, and a painful "crisis" in the arms or legs from lack of oxygen. In sickle cell patients, the red blood cells are sickle or crescent shaped, carry less oxygen, and can get stuck in small blood vessels. A carrier has "sickle cell trait" with milder symptoms. If *both parents* are carriers, the baby has a 25% chance to have sickle cell disease. The risk of sickle cell is higher in African, African American, Mediterranean, South and Central American, Caribbean, and Middle Eastern backgrounds.

□ I wish to have sickle cell testing. (signature and date) _____

OR □ I decline sickle cell testing. (signature and date) _____

TAY-SACHS TESTING

Tay-Sachs is a genetic disease (due to a defective gene on chromosome 15) which causes nerve / brain damage to the fetus (during pregnancy). Symptoms appear by a few months of age and the child usually dies by age 5. A person can be a "carrier" of the Tay-Sachs gene and have no symptoms. If *both parents* are carriers, the baby has a 25% chance to have Tay-Sachs. The risk of Tay-Sachs is higher in Eastern European Jewish, Cajun, and French-Canadian backgrounds.

□ I wish to have Tay-Sachs testing. (signature and date)_____

OR □ I decline Tay-Sachs testing. (signature and date) _____

ALPHA-THALASSEMIA and/or βETA-THALASSEMIA

Thalassemia is a genetic disease which causes anemia (mild to severe). Red blood cells use hemoglobin to carry oxygen. Hemoglobin is made of alpha and beta globin chains, which are defective or absent in thalassemia. Thalassemia is more complicated than other genetic diseases because more genes involved. A person can be a "carrier" of thalassemia and have no symptoms, or have thalassemia "minor" (with mild anemia). If *both parents* carry defective genes, the baby can develop thalassemia "major", with stillbirth, severe anemia and death. The risk of thalassemia is higher in Chinese, Pilipino, Taiwanese, and African / African American (also Middle Eastern for alpha thalassemia and Mediterranean, Italian, Greek for beta-thalassemia) backgrounds.

□ I wish to have αlpha & βeta-Thalassemia testing. (signature and date) _____

OR □ I decline αlpha & βeta-Thalassemia testing. (signature and date)_____

SPINAL MUSCULAR ATROPHY (SMA)

SMA is a genetic disease which causes worsening muscle weakness, paralysis and death, due to damage in the motor nerves that control muscle movement. A baby with SMA may not be able to crawl, sit, walk, or (in severe cases) swallow or breathe. The risk of being a carrier is 1/80. If *both parents* are carriers, the baby has a 25% chance to have SMA.

□ I wish to have SMA testing. (signature and date)_____

OR □ I decline SMA testing. (signature and date) _____

REVIEW OF SYSTEMS - Please fill in every box and answer every question.
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 withdrawl
- ❑ 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
- ❑ withdrawl ("pulling out")
- ❑ rhythm / natural family planning
- ❑ condoms
- ❑ IUD
- ❑ DepoProvera
- ❑ 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: _____

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: _____

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 or download from our practice website. I hereby acknowledge that I have been given the opportunity to read a copy of the Notice of Privacy Practices for Amber Health Care for Women.

Patient signature:_____Date: _____

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

1) by phone for all biopsy results (normal or abnormal)
2) by mail (sent directly from the lab) for normal pap smear results
3) by mail (sent directly from the radiology center) for normal mammogram results
4) by mail (sent from our office) for other normal test results
5) by phone (and by mail if we cannot reach you by phone) for abnormal results, for results that necessitate further testing or treatment, and for lab problems (such as an inadequate specimen).

If you do not hear from our office by two weeks after tests are performed, please contact us.

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 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 to any individual other than myself, except as explained in the Notice of Privacy Practices.

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 other individuals.

- 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: _____

MEDICAL RECOMMENDATIONS

Annual physical exams – Every woman should have a full physical exam once a year, to screen for diseases such as high blood pressure and cancer of the skin, breast, cervix, and ovary. An OB-GYN specialist treats issues such as birth control, pregnancy, PMS, menopause, heavy or painful periods, and pelvic prolapse. 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. Occasionally a mammogram may miss a cancer, so you may need other tests if you have a breast lump, breast pain, black or bloody nipple discharge, or dense breasts. We recommend monthly self breast exams, and for a woman age 40 and older a yearly mammogram.

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. A screening colonoscopy should be done every 10 years after the age of 50), and more often in a high risk patient.

Dexascan – A Dexascan is a scanning 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 the point of causing a hunched back or broken bones. A Dexascan should be done periodically in all post-menopausal women, and for certain other high risk patients.

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. Using a condom during sex lowers the risk of catching an STD. Some STDs (like HIV and hepatitis) can also be spread by blood (from transfusions, needle sticks or IV drug abuse). 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 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 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 childhood 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:_____