

## PATIENT DEMOGRAPHIC INFORMATION

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 insurance or demographic information. Forms and office policies are available for download at [Amberhealthcareforwomen.com](http://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: \_\_\_\_\_

Marital 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  HealthGrades.com  Doctor referral  Phone Book  
 Insurance Provider List  Practice Brochure  Magazine Ad  Mercy/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 Amber Health Care for Women will bill my insurance plan, and bill me for any remaining balance - such as charges applied towards my deductible 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 for Amber Health Care for Women: Co-payments are due at time of service; delinquent 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 \$50 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 reasonable attorney's fees. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient / Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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: \_\_\_\_\_

**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 today?

1) CONSTITUTIONAL <input type="checkbox"/> fever <input type="checkbox"/> none <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain <input type="checkbox"/> fatigue <input type="checkbox"/> sleep problems <input type="checkbox"/> loss of appetite	5) ALLERGIC <input type="checkbox"/> latex allergy <input type="checkbox"/> none <input type="checkbox"/> betadine allergy <input type="checkbox"/> sinus drainage <input type="checkbox"/> sneezing <input type="checkbox"/> hay fever <input type="checkbox"/> hives / swelling	8) MUSCULOSKELETAL <input type="checkbox"/> joint pain <input type="checkbox"/> none <input type="checkbox"/> muscle weakness	12) RESPIRATORY <input type="checkbox"/> wheezing <input type="checkbox"/> none <input type="checkbox"/> cough <input type="checkbox"/> coughing blood <input type="checkbox"/> shortness of breath <input type="checkbox"/> painful breathing
2) PSYCHIATRIC <input type="checkbox"/> depression <input type="checkbox"/> none <input type="checkbox"/> severe anxiety <input type="checkbox"/> crying spells	6) ENDOCRINE <input type="checkbox"/> heat intolerance <input type="checkbox"/> none <input type="checkbox"/> cold intolerance <input type="checkbox"/> excessive hair loss <input type="checkbox"/> excessive hair growth	9) EARS - NOSE - THROAT <input type="checkbox"/> ear pain <input type="checkbox"/> none <input type="checkbox"/> hearing loss <input type="checkbox"/> ringing in your ears <input type="checkbox"/> sore throat <input type="checkbox"/> nose bleeds <input type="checkbox"/> cold sores	13) GASTROINTESTINAL <input type="checkbox"/> bloating / gas <input type="checkbox"/> none <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> abdominal pain <input type="checkbox"/> bloody stool or black stool <input type="checkbox"/> indigestion / reflux <input type="checkbox"/> nausea / vomiting <input type="checkbox"/> jaundice (yellow skin)
3) EYES <input type="checkbox"/> blurred vision <input type="checkbox"/> none	7) BREASTS - SKIN <input type="checkbox"/> breast pain <input type="checkbox"/> none <input type="checkbox"/> breast lumps <input type="checkbox"/> breast discharge <input type="checkbox"/> dry or scaly skin <input type="checkbox"/> rashes / itching <input type="checkbox"/> skin ulcers or lesions <input type="checkbox"/> acne	10) HEME - LYMPHATIC <input type="checkbox"/> bruising easily <input type="checkbox"/> none <input type="checkbox"/> bleeding easily <input type="checkbox"/> painful varicose veins <input type="checkbox"/> swollen glands / lymph nodes	14) GU - URINARY <input type="checkbox"/> bloody urine <input type="checkbox"/> none <input type="checkbox"/> frequent urination <input type="checkbox"/> urgent urination <input type="checkbox"/> painful urination <input type="checkbox"/> incomplete bladder emptying <input type="checkbox"/> incontinence of urine
4) NEUROLOGIC <input type="checkbox"/> headache <input type="checkbox"/> none <input type="checkbox"/> seizures <input type="checkbox"/> fainting or dizziness <input type="checkbox"/> severe memory loss <input type="checkbox"/> trouble walking <input type="checkbox"/> numbness		11) CARDIOVASCULAR <input type="checkbox"/> chest pain <input type="checkbox"/> none <input type="checkbox"/> palpitations <input type="checkbox"/> leg swelling <input type="checkbox"/> need to sleep propped up <input type="checkbox"/> short of breath with activity	

GU - GYNECOLOGY <input type="checkbox"/> pelvic pain <input type="checkbox"/> none <input type="checkbox"/> low libido (sex drive) <input type="checkbox"/> vaginal itching <input type="checkbox"/> vaginal discharge <input type="checkbox"/> vaginal odor <input type="checkbox"/> abnormal bleeding	Menopause symptoms <input type="checkbox"/> hot flashes <input type="checkbox"/> none <input type="checkbox"/> night sweats <input type="checkbox"/> mood swings <input type="checkbox"/> vaginal dryness	When was your last period? _____ <i>If having periods:</i> How often do you have a period? _____ How many days do your periods last? _____ Describe your bleeding: <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy Describe your menstrual cramps: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
PMS: occurring every month, but only 1-2 weeks before your period <input type="checkbox"/> angry outbursts <input type="checkbox"/> none <input type="checkbox"/> irritability <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> social withdrawl <input type="checkbox"/> headache <input type="checkbox"/> breast pain <input type="checkbox"/> bloating <input type="checkbox"/> swelling	Birth Control Method (current) <input type="checkbox"/> tubes tied <input type="checkbox"/> none <input type="checkbox"/> vasectomy <input type="checkbox"/> abstinence <input type="checkbox"/> rhythm / natural family planning <input type="checkbox"/> withdrawal ("pulling out") <input type="checkbox"/> condoms <input type="checkbox"/> diaphragm <input type="checkbox"/> IUD <input type="checkbox"/> DepoProvera <input type="checkbox"/> Nuvaring <input type="checkbox"/> birth control patch <input type="checkbox"/> birth control pills	Yes / No <input type="checkbox"/> / <input type="checkbox"/> Do you ever skip periods? <input type="checkbox"/> / <input type="checkbox"/> Do you have bleeding in between your periods? <input type="checkbox"/> / <input type="checkbox"/> Do you soak through to your clothes? <input type="checkbox"/> / <input type="checkbox"/> Do you pass blood clots? How large? _____ <input type="checkbox"/> / <input type="checkbox"/> Do your periods limit your activities? <input type="checkbox"/> / <input type="checkbox"/> Are you currently breast feeding? <input type="checkbox"/> / <input type="checkbox"/> Do you do self breast exams? If yes, how often? _____ <input type="checkbox"/> / <input type="checkbox"/> Are you sexually active? <i>If sexually active:</i> <input type="checkbox"/> / <input type="checkbox"/> Do you have pain with sex? <input type="checkbox"/> / <input type="checkbox"/> Do you have bleeding with sex? <input type="checkbox"/> / <input type="checkbox"/> Do you use condoms? <input type="checkbox"/> / <input type="checkbox"/> Do you currently have more than one sexual partner? Are your sexual partners: <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> both
Yes / No <input type="checkbox"/> / <input type="checkbox"/> Would you like to be tested for sexually transmitted diseases? <input type="checkbox"/> / <input type="checkbox"/> In the past 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 marital status?  
Yes / No If yes, how much / how often?  
 /  exercise?  
 /  caffeine? (colas / coffee / tea)  
 /  alcohol?  
 /  smoking?  
 /  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: \_\_\_\_\_

Please fill in every box and answer every question. If you answer yes, please give details and year of diagnosis

**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 thrombosis (DVT) - blood clots in legs
  - pulmonary embolus (PE) - blood clots in lungs
  - systemic lupus erythematosus (SLE)
  - anti-phospholipid antibody syndrome
  - seizures / epilepsy
  - osteopenia or osteoporosis
  - arthritis
  - asthma
  - COPD
  - heart murmur
  - mitral valve prolapse or other valvular disease
  - coronary artery disease or heart attack
  - high cholesterol
  - high blood pressure
  - stroke
  - gastric reflux / GERD
  - hiatal hernia
  - ulcers (stomach or intestines)
  - liver cirrhosis
  - gallstones
  - irritable bowel disease
  - Crohn's disease or ulcerative colitis
  - diverticulosis or diverticulitis
  - eating disorder: anorexia or bulimia
  - clinical depression, or anxiety, or bipolar disorder
  - alcoholism or drug abuse
  - skin disease: psoriasis, eczema, or lichen sclerosus
  - breast cancer
  - ovarian cancer
  - colon cancer
  - skin cancer
  - other cancer
  - other chronic or serious illness:
  - fibrocystic breast disease
  - uterine fibroids
  - polycystic ovarian syndrome (PCOS)
  - endometriosis
  - infertility
  - abnormal pap smear (how treated?)
  - Have you ever been physically abused?
  - Have you ever been sexually abused or raped?
  - Have you ever had a blood transfusion?
  - Are you a Jehovahs Witness who refuses blood products?
  - Have you had any surgeries?

**INFECTIOUS DISEASE HISTORY** Have YOU ever had:

- Yes / No Yes / No
- chicken pox
  - shingles
  - positive PPD test
  - tuberculosis (TB)
  - measles, mumps, rubella, polio, malaria, or yellow fever
  - Have you been vaccinated for  HPV /  HepB /  TB?
  - sexually transmitted diseases:
    - Gonorrhea  Chlamydia  PID
    - HIV / AIDS  Trichomonas  syphilis
    - Herpes  genital warts  HPV on pap smear
  - scarlet fever
  - hepatitis A
  - hepatitis B
  - 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?

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## 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: \_\_\_\_\_