

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

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: _____

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?	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	_____
Do you smoke? (tobacco or cigars)	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	_____
Do you use marijuana?	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	_____
Do you use street drugs (what type)?	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>	_____

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

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

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?

- | | | |
|--|--|---|
| <input type="checkbox"/> incompetent cervix | <input type="checkbox"/> pre-eclampsia / PIH | <input type="checkbox"/> none |
| <input type="checkbox"/> preterm labor | <input type="checkbox"/> placenta previa | <input type="checkbox"/> gestational diabetes |
| <input type="checkbox"/> IUGR (growth restriction) | <input type="checkbox"/> Rh isoimmunization | <input type="checkbox"/> placental abruption |
| <input type="checkbox"/> problems during labor | | <input type="checkbox"/> 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 call with Dr. VanKirk, Dr. Pena, Dr. Oliva, Dr. Williams, Dr. Skipitis, and Dr. Keurentjes. 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). None of these doctors work 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. We do not accept patients who take "medical marijuana" during pregnancy.

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 not 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 BETA-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 alpha & beta-Thalassemia testing. (signature and date) _____
- OR I decline alpha & beta-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 today?

1) CONSTITUTIONAL <input type="checkbox"/> fever <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	<input type="checkbox"/> none	5) ALLERGIC <input type="checkbox"/> latex allergy <input type="checkbox"/> betadine allergy <input type="checkbox"/> sinus drainage <input type="checkbox"/> sneezing <input type="checkbox"/> hay fever <input type="checkbox"/> hives / swelling	<input type="checkbox"/> none	8) MUSCULOSKELETAL <input type="checkbox"/> joint pain <input type="checkbox"/> muscle weakness	<input type="checkbox"/> none	12) RESPIRATORY <input type="checkbox"/> wheezing <input type="checkbox"/> cough <input type="checkbox"/> coughing blood <input type="checkbox"/> shortness of breath <input type="checkbox"/> painful breathing	<input type="checkbox"/> none
2) PSYCHIATRIC <input type="checkbox"/> depression <input type="checkbox"/> severe anxiety <input type="checkbox"/> crying spells	<input type="checkbox"/> none	6) ENDOCRINE <input type="checkbox"/> heat intolerance <input type="checkbox"/> cold intolerance <input type="checkbox"/> excessive hair loss <input type="checkbox"/> excessive hair growth	<input type="checkbox"/> none	9) EARS - NOSE - THROAT <input type="checkbox"/> ear pain <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	<input type="checkbox"/> none	13) GASTROINTESTINAL <input type="checkbox"/> bloating / gas <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)	<input type="checkbox"/> none
3) EYES <input type="checkbox"/> blurred vision	<input type="checkbox"/> none	7) BREASTS - SKIN <input type="checkbox"/> breast pain <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	<input type="checkbox"/> none	10) HEME - LYMPHATIC <input type="checkbox"/> bruising easily <input type="checkbox"/> bleeding easily <input type="checkbox"/> painful varicose veins <input type="checkbox"/> swollen glands / lymph nodes	<input type="checkbox"/> none	14) GU - URINARY <input type="checkbox"/> bloody urine <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	<input type="checkbox"/> none
4) NEUROLOGIC <input type="checkbox"/> headache <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	<input type="checkbox"/> none			11) CARDIOVASCULAR <input type="checkbox"/> chest pain <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	<input type="checkbox"/> none		

GU - GYNECOLOGY <input type="checkbox"/> pelvic pain <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	<input type="checkbox"/> none	Menopause symptoms <input type="checkbox"/> hot flashes <input type="checkbox"/> night sweats <input type="checkbox"/> mood swings <input type="checkbox"/> vaginal dryness	<input type="checkbox"/> none	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"/> irritability <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> social withdrawal <input type="checkbox"/> headache <input type="checkbox"/> breast pain <input type="checkbox"/> bloating <input type="checkbox"/> swelling	<input type="checkbox"/> none	Birth Control Method (current) <input type="checkbox"/> tubes tied <input type="checkbox"/> vasectomy <input type="checkbox"/> abstinence <input type="checkbox"/> rhythm / natural family planning <input type="checkbox"/> withdrawl ("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	<input type="checkbox"/> none	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? Yes / No <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 _____ miscarriages
 _____ full term births (after 37 wks) _____ stillbirth
 _____ preterm birth (before 37 wks) _____ abortions
 _____ tubal / ectopic pregnancies _____ living children

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

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: _____