## 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 uupdates to your insurace or demographic information. Forms and office policies are available for download at Amberhealthcareforwomen.com

Patiend 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: _____

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 ❑ 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 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 for AMber Health Care for Women: 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 agencvy; 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 agreee 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.

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

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

3) EYES
- ❑ blurred vision ❑ none

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

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
- ❑ angry outbursts ❑ none
- ❑ irritability
- ❑ depression
- ❑ anxiety
- ❑ social withdrawl
- ❑ headache
- ❑ breast pain
- ❑ bloating
- ❑ swelling

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

Birth Control Method (current)
- ❑ tubes tied ❑ none
- ❑ vasectomy
- ❑ abstinence
- ❑ rhythm / natural family planning
- ❑ withdrawl ("pulling out")
- ❑ condoms
- ❑ diaphragm
- ❑ IUD
- ❑ DepoProvera
- ❑ Nuvaring
- ❑ 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?
- ❑ / ❑ 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 maritial status?
Yes / No If yes, how much / how often?
- ❑ / ❑ exercise?
- ❑ / ❑ caffeine? (colas / coffee / tea)
- ❑ / ❑ alcohol?
- ❑ / ❑ tobacco?
- ❑ / ❑ 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 physically abused?
- ❑ ❑ Have you ever been sexually abused or raped?
- ❑ ❑ Have you ever had a blood transfusion?
- ❑ ❑ Are you a Jehovas Witness who refuses blood products?

## INFECTIOUS DISEASE HISTORY Have YOU ever had:

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

Yes / No

- ❑ ❑ 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? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

❑ ❑ Have you had any surgeries?

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:_____