NEW PATIENT MEDICAL HISTORY OB/GYN

Name:	Birth Date
Date:	Age

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.

Please check each question that applies to you. Put (?) if uncertain.

What brought you to see the doctor? (onset of symptoms, current problems, previous treatment, current treatment)

_____

_____

☐Yes ☐No Are you now in poor health or suffering from any chronic physical or mental condition?

☐Yes ☐No Have you had any x-rays taken in the past 5 years?
List Type: _____

☐Yes ☐No Have you had any laboratory tests done in the past 2 years?
List type and result: _____

☐Yes ☐No Have you ever had a blood transfusion?

☐Yes ☐No Do you have any special religious convictions which might affect your treatment? If yes, explain:

_____

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY:

Date of last menstrual period: _____ Date of previous period: _____

Age at first period: _____ Menstrual flow usually lasts for a total of _____ days.

Have you missed periods without being pregnant? ..... ☐Yes ☐No

When NOT on birth control pills, are your periods: ☐Regular ☐Somewhat Regular ☐Completely Irregular

The interval between first day of one period to first day of next period ranges from _____ to _____ days.

Menstrual flow usually is: ☐Scant ☐Moderate ☐Heavy ☐Excessive with clots

Are your periods usually painful? ..... ☐Yes ☐No

If painful: ☐Mild ☐Moderate ☐Severe ☐Incapacitating

Do you ever have any pain with sexual intercourse? ..... ☐Yes ☐No

Do you now or have you ever had a problem with infertility? ..... ☐Yes ☐No

If not menstruating, stopped at age _____. Any bleeding or spotting since? ..... ☐Yes ☐No

Do you have any abdominal or pelvic pain unrelated to menstruation? ..... ☐Yes ☐No

Do you have any other complaint, concern or question regarding sex? ..... ☐Yes ☐No

Do you have any vaginal or vulva irritation, heavy discharge or dryness? ..... ☐Yes ☐No

Do you frequently have loss of urine with sneezing and coughing? ..... ☐Yes ☐No

Do you have frequent night urination, dribbling or urine or bedwetting? ..... ☐Yes ☐No

Do you have a protrusion or bulging sensation from your vagina? ..... ☐Yes ☐No

Contraception type: _____

Have you ever had an ABNORMAL Pap smear? ☐Yes ☐No Date: _____

Date of last Pap smear: _____

OBSTETRIC HISTORY:

How many pregnancies? _____

How many live births? _____

Number of stillbirths? _____

How many prematures (less than 5 1/2 lbs.) born alive? ___

What was the largest baby's weight: _____

Any serious complications with any pregnancy? Explain: ___

_____

How many miscarriages? _____

How many abortions? _____

Have all your children been normal? ☐Yes ☐No

My blood is: ☐Rh Positive ☐Negative ☐Uncertain

How many living children do you have? _____

Year oldest born: _____

Date of last delivery: _____

PERSONAL HISTORY

INFECTIOUS DISEASE: Check any of the following diseases you have had.

☐ Measles	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Bladder or Kidney Infection
☐ German Measles (Rubella)	☐ Tuberculosis	☐ Encephalitis	☐ Venereal Disease
☐ Mumps	☐ Hepatitis	☐ Meningitis	☐ Chicken Pox
☐ Polio	☐ Pneumonia	☐ Tubal Infection	☐ Herpes

☐ Other: _____

SURGERY:

	Year		Year		Year
☐ Appendix	_____	☐ Tumor of Any Kind	_____	☐ Ovary	_____
☐ Gall Bladder	_____	☐ Varicose Veins	_____	☐ Tubes	_____
☐ Kidney Stones	_____	☐ Hernia	_____	☐ Uterus (Womb)	_____
☐ Tonsils	_____	☐ Hemorrhoids	_____	☐ Vagina or Bladder	_____
☐ Thyroid	_____	☐ Chest	_____	☐ Cesarean Section	_____
☐ Breast	_____	☐ Spine	_____	☐ D and C	_____

Others: _____

Have you ever been advised to have any surgical operation which has not been done before? ☐ Yes ☐ No

ILLNESSES: Check any of the following diseases you have had.

☐ Anemia	☐ Blood Clots or Phlebitis	☐ Hernia	☐ HIV/AIDS
☐ Bleeding Disorder	☐ Heart Murmur	☐ Hemorrhoids	☐ Asthma
☐ Jaundice	☐ High Blood Pressure	☐ Colitis	☐ Convulsion
☐ Diabetes	☐ Ulcer	☐ Arthritis	☐ Kidney Stone
☐ Cancer	☐ Gall Bladder Trouble	☐ Bone Disease	☐ Nervous Breakdown
☐ Migraine	☐ Chronic Diarrhea	☐ Back Trouble	☐ Varicose Veins

Others: _____

Have you ever been hospitalized for any illness? ☐ Yes ☐ No

Diagnosis and Year: _____

MEDICATIONS:

	Never	Not in Past Year	Occasionally	Frequently	Daily	Name of Medication
Cortisone or Steroid	☐	☐	☐	☐	☐	_____
Blood Pressure Pills	☐	☐	☐	☐	☐	_____
Thyroid	☐	☐	☐	☐	☐	_____
Heart Medicine	☐	☐	☐	☐	☐	_____
Diuretic (Water) Pills	☐	☐	☐	☐	☐	_____
Tranquilizer or Nerve Pills	☐	☐	☐	☐	☐	_____
Appetite Suppressant or Pep Pills	☐	☐	☐	☐	☐	_____
Hormone Pill or "Shots"	☐	☐	☐	☐	☐	_____
Sleeping Pill	☐	☐	☐	☐	☐	_____
Asthma Medicine	☐	☐	☐	☐	☐	_____
Arthritis Medicine	☐	☐	☐	☐	☐	_____
Birth Control Pills	☐	☐	☐	☐	☐	_____

Others: _____

Are you allergic or have you had any reaction or side effects from drugs, vaccines or other agents? ☐ Yes ☐ No

☐ Aspirin ☐ Pain Medicine ☐ Penicillin ☐ Sulfa ☐ Novocaine ☐ Birth Control Pills

Other: _____

FAMILY HISTORY

	SEX		AGE (If Living)	HEALTH	IF DECEASED AGE AT DEATH	IF DECEASED CAUSE	Has any blood relative ever had (please check):		Who?
Father							Diabetes		
Mother							Tuberculosis		
Siblings		1.					High Blood Pressure		
		2.					Epilepsy		
		3.					Heart Disease		
		4.					Stroke		
		5.					Glaucoma		
Children		1.							
		2.							
		3.					Cancer Type		Who?
		4.							
		5.							

SOCIAL HISTORY

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

No. of Marriages: _____

Occupation: _____

Highest Level of Education: _____ Degrees: _____

Spouse Occupation: _____

Habits: Tobacco: ☐ Yes ☐ No

No. packs per day: _____

No. of years: _____

Alcohol: ☐ Never

☐ Rare

☐ 3 - 5 drinks per week

☐ 6 - 10 drinks per week

☐ More than 10 drinks per week

Drugs: Now:

Names and how much: _____

_____

Past:

Names and how much: _____

_____

Northern Nevada Women's Health
OB/GYN

Today's Date _____ (please fill out ALL sections completely and legibly).

DEMOGRAPHIC INFORMATION – Section A

Patient Name _____

Patient's Birth Date ____/____/_____ Patient's Social Security Number _____/_____/_____

Status: Child □ Married □ Single □ Separated □ Divorced □ Widow □

Race: African American or Black / Asian / Pacific Islander / American Indian / White / Other

Ethnicity: Hispanic / Non Hispanic or White Preferred Language_____

Mailing Address_____City_____State_____Zip_____

E-Mail Address_____

Home Phone _____Cell Phone: _____Work Phone: _____

Parent/Guardian Name_____Phone Number_____

Address (if different than patient) _____

Emergency contact_____Phone Number_____

INSURANCE INFORMATION – Section B *Are you the subscriber?* _____

Policy Name _____ID/Group Number _____

Policy Holder's Name_____

Birth Date _____/_____/_____ Soc. Sec._____/_____/_____

Relationship to patient (if not the subscriber)_____

Secondary Policy Name_____ID/Group Number_____

Policy Holder's Name_____

Birth Date_____/_____/_____ Soc. Sec._____/_____/_____

Relationship to patient (if not the subscriber)_____

I understand that I am financially responsible for all charges for services rendered to me from Northern Nevada Women's Health. I hereby authorize Northern Nevada Women's Health to furnish my insurance carrier all information which my insurance carrier requests concerning my diagnoses and treatment for payment purposes. I hereby assign Northern Nevada Women's Health all monies from my insurance carrier for services rendered. I understand and acknowledge that I am responsible to Northern Nevada Women's Health for any deductibles and/or charges not covered or not required to be discounted by this agreement.

Patient Signature_____Date____/____/____

Signature (if patient is a minor)_____Date____/____/____

Northern Nevada Women's Health
OB/GYN

Today's Date _____ (please fill out ALL sections completely and legibly).

DEMOGRAPHIC INFORMATION – Section A

Patient Name _____

Patient's Birth Date ____/____/_____ Patient's Social Security Number _____/____/_____

Status: Child □ Married □ Single □ Separated □ Divorced □ Widow □

Race: African American or Black / Asian / Pacific Islander / American Indian / White / Other

Ethnicity: Hispanic / Non Hispanic or White Preferred Language_____

Mailing Address_____City_____State_____Zip_____

E-Mail Address_____

Home Phone _____Cell Phone: _____Work Phone: _____

Parent/Guardian Name_____Phone Number_____

Address (if different than patient) _____

Emergency contact_____Phone Number_____

INSURANCE INFORMATION – Section B *Are you the subscriber?* _____

Policy Name _____ID/Group Number _____

Policy Holder's Name_____

Birth Date _____/_____/_____ Soc. Sec._____/_____/_____

Relationship to patient (if not the subscriber)_____

Secondary Policy Name_____ID/Group Number_____

Policy Holder's Name_____

Birth Date_____/_____/_____ Soc. Sec._____/_____/_____

Relationship to patient (if not the subscriber)_____

I understand that I am financially responsible for all charges for services rendered to me from Northern Nevada Women's Health. I hereby authorize Northern Nevada Women's Health to furnish my insurance carrier all information which my insurance carrier requests concerning my diagnoses and treatment for payment purposes. I hereby assign Northern Nevada Women's Health all monies from my insurance carrier for services rendered. I understand and acknowledge that I am responsible to Northern Nevada Women's Health for any deductibles and/or charges not covered or not required to be discounted by this agreement.

Patient Signature_____Date____/____/____

Signature (if patient is a minor)_____Date____/____/____

Northern Nevada Women's Health
1865 Plumas Street Suite 1 Reno NV 89509 P. 775-786-7440 F. 775-786-9389

Financial Policy

Thank you for choosing Northern Nevada Women's Health to participate in your medical care. In an effort to provide you with a full understanding of your financial obligations, an important aspect of your medical care, we have developed the following policies:

All patients are financially responsible for services rendered

- Northern Nevada Women's Health requires that you provide a copy of your current insurance card and photo ID at every visit.
- It is the patient's responsibility to know their insurance policies, terms, conditions and limitations.
- As a requirement by your insurance company, co-payments, deductibles and co-insurances fees are due at the time of service.
- ***Medicare*** recipients are expected to update the National File with any changes by calling 1-800-MEDICARE.
- **Self Pay:** Payment is required in full at the time of service.
- If previous arrangements have not been made, any account over 90 days will be reviewed and turned over to a collection agency.
- A fee of $25.00 will be charged for returned checks as well as any bank fees incurred.

Medicaid Responsibility

- As a member, you must present your proof of Medicaid coverage at every visit. Medicaid eligibility will be verified prior to your visit. If Medicaid shows that you have another insurance the claim for services rendered will be rejected and it will become your responsibility to correct it.
- Medicaid may audit a claim at any time, and if they find that another insurance was on file they will request a refund for any claims paid. If that happens all monies due will become your responsibility.
- In the event you are not eligible during the month of your appointment you will be responsible for services rendered, and if you are unable to provide payment for those services your appointment may be cancelled.
- **PLEASE NOTE:** It is your responsibility to keep your Medicaid coverage current.

Appointments

- Please provide at least 24 hours' notice to cancel an appointment
- After your second "No Show" for a scheduled appointment, management reserves the right to assess a $25.00 fee.
- Patients who accumulate a total of three "No Shows" in a calendar year may be terminated from the practice.

Referrals/Authorizations

It is the patient's responsibility to ensure that any referrals or authorizations for treatment are provided to our office prior to your appointment. If the authorization or referral is not obtained prior to your visit, you will be expected to pay for all charges at the time of visit or be rescheduled for another time.

I have read and understand the Financial Policy and agree to comply accept responsibility for services provided by Northern Nevada Women's Health.

Signature _____ Date _____

Northern Nevada Women's Health

1865 Plumas Street Suite 1 Reno NV 89509 P. 775-786-7440 F. 775-786-9389

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of your Protected Health Information

- Your protected health information will be used by Northern Nevada Women's Health or disclosed to others only for the purposes of treatment, obtaining payment or supporting the day-to- day health care operations.

Notice of Privacy Practices

- You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your protected health information. Northern Nevada Women's Health may not agree to restrict the use or disclosure of your protected health information. If Norther Nevada Women's Health agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the Federal Policy standards.

Revocation of Consent

- You may revoke this consent to the use and disclosure of your protected health information in writing. Any use or disclosure that has already occurred prior to the date on which the revocation of consent is received will not be affected.

Reservation of Right to change Privacy Practices

- Northern Nevada Women's Health reserves the right to modify the practices outlined in the notice.

Signature

I have reviewed this consent form and the Notice of Privacy Practice for Northern Nevada Women's Health. I give my permission to use and disclose my health information in accordance with it.

_____

Name of Patient (print please)

_____

Signature of Patient/Guardian Date

Northern Nevada Women's Health

1865 Plumas Street Suite 1 Reno NV 89509 P. 775-786-7440 F.775-786-9389

PATIENT CONTACT INFORMATION

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding;

- appointment reminds
- lab results
- medications
- Any other medical related issue

If we cannot reach you at any of these numbers, please indicate the numbers where we can leave a message.

Home _____ Message OK? YES NO

Work _____ Message OK? YES NO

Cell Phone _____ Message OK? YES NO

Other _____ Message OK? YES NO

If you wish for us to speak with someone about your care, treatment or billing issues, please indicate whom we are authorized to speak with. Please write their name as well as indicate the relationship.

Husband / Wife _____ Phone _____

Son / Daughter _____ Phone _____

Son / Daughter _____ Phone _____

Other _____ Name _____ Phone _____

Other _____ Name _____ Phone _____

I understand that I may revoke this authorization at any time in writing at any time except to the extent that action has been taken in reliance on the authorization.

Patient Name _____ Print Name _____ Date _____

If not signed by the patient, please indicate your relationship to the patient _____

Northern Nevada Women's Health
1865 Plumas Street Suite 1 Reno NV 89509 P. 775-786-7440 F. 775-786-9389

Controlled Substance Policy

I,_____Date of Birth_____

- Do agree that all of my narcotics/restricted medications will be used for the purpose that they were prescribed for and will only be used by myself.
- I will not be allowed any early refills for lost or stolen controlled medications including lost scripts.
- In the event of theft of controlled medications I understand the office requires a copy of a filed police report (this does not guarantee a refill).
- I will call during normal business hours for any needed refills and understand that 72 hours may be required to complete refill requests.
- I will have all of my controlled medications refilled through this office and will not receive these medications from other providers.
- I understand that Northern Nevada Women's Health will access my medication history through the Nevada Prescription Monitoring Program.
- If I show evidence of misuse, abuse or lying about my controlled medication use, to include receiving medications from other physicians, I understand that this will be grounds for stopping any further refills and/or dismissal from this practice.

By signing below I understand the above mentioned and will comply in order to continue to receive my controlled medications here.

_____

Patient/Guardian Signature Date

Northern Nevada Women's Health
1865 Plumas Street Reno NV 89509 P. 775-786-7440 F. 775-786-9389

FAMILY AND PREGNANCY HISTORY

Patient Name_____Date of Birth _____

Has anyone in your family or your partners family ever had:

Down Syndrome	YES	NO
Spina Bifida	YES	NO
Hemophilia	YES	NO
Muscular Dystrophy	YES	NO
Congenital Heart Defect	YES	NO
Mental Retardation	YES	NO
Any other Type of Birth Defect	YES	NO

If yes please describe_____

	YES	NO
Will you be age 35 or older when the baby is born?	YES	NO
Do you have Insulin Dependant Diabetes?	YES	NO
Have you (or the babys father in a previous union) had 3 or more micarriages	YES	NO
Have your (or the babys father) during or immediatley prior to this pregnancy:		
Taken any drugs or medications	YES	NO
Been exposed to any x-rays, chemical or toxic substances	YES	NO

If yes: please describe_____

Have you ever been tested to determine if you are immune to Rubella	YES	NO

*Certain genetic diseases are more common in certain ethnic groups

Are you or babys father African American?	YES	NO
Screened for Sickle Cell Trait?	YES	NO
Are you or babys father East, European Jewish?	YES	NO
Screened for Tay-Sachs disease?	YES	NO
Do you or babys father have Mediterranean or SE Asian Heritage?	YES	NO
Screened for Thalassemia (Cooley's Anemia)	YES	NO

Northern Nevada Women's Health
1865 Plumas Street Suite 1 Reno NV 89509 P. 775-786-7440 F. 775-786-9389

HIV ANTIBODY TESTING CONSENT

I,_____, hereby consent and agree to HIV antibody testing of my blood. I have been informed, understand and agree that my blood will be tested in order to detect evidence of antibodies to the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that HIVE test's accuracy and reliability is not certain in that the test may, in some cases:

1. Indicate that a person has antibodies to the probable causative agent of AIDS when the person does not.
2. Indicate that the person has antibodies to the probable causative agent of AIDS when the person does not have AIDS virus or any AIDS related syndrome or condition.
3. And, may fail to reveal when a person has antibodies to the probable causative agent of AIDS.

- I have been informed that the HIV test is performed by withdrawing blood and using a substance to test the blood. I also have been informed that currently there are no other blood tests that may be used to identify the presence of antibodies to the probable causative agent of AIDS and that there are other means of diagnosing AIDS which can be used in conjunction with the blood test.

- I have been informed that any questions I have regarding the nature of the blood tests, its expected benefits, its risk and alternative tests may be asked for before I decide whether to consent to the blood test. I have asked and been given answers to any questions I had.

I have read the foregoing and acknowledge that I have been given all information I desire concerning the blood test to detect antibodies in the probable causative agent of AIDS. I further consent and agree to give a sample of my blood to the appropriate qualifying laboratory to test for the evidence of antibodies to the probable causative agent of AIDS.

_____

Signature of Patient/Guardian Date

Northern Nevada Women's Health
1865 Plumas Street Reno NV 89509 P. 775-786-7440 F. 775-786-9389

Tubal Ligation Policy

If you elect to have a tubal ligation after pregnancy it won't be performed until after your 6 week post-partum visit, which will be scheduled accordingly.

****Please note:** If you have Medicaid, you are required to sign a specific for that states that you are 21 years of age or older and the procedure cannot be performed until 31 days or more from the date of your signature.

Obstetric Ultrasounds

It is important that you understand your insurance benefits for your maternity care. There are certain obligations that your insurance requires you to uphold. Your failure to comply may result in reduced payment or denial of your entire claim.

Please verify how many ultrasounds your insurance plan covers. ***An ultrasound for the purpose of learning the gender of your baby is not covered and not considered medically necessary. Any patient wanting an ultrasound for this reason will be responsible for the payment of $150.00.***

I have been advised that I will be financially responsible for services considered to be a non-covered services by my insurance company.

Patient Name

Patient/Guardian Signature Date

Northern Nevada Women's Health
Ultrasound Policy & Notice

Ultrasounds are a very important diagnostic procedure. During an ultrasound appointment it is imperative that the patient have an optimal experience with minimal distractions and interruptions. The care of the patient and baby are our priority.

- Due to the equipment, hazardous material and nature of the appointment there will be **No Children allowed in the Ultrasound room, please make sure other arrangements are made. If you arrive with children you will need to reschedule your appointment.**

- Patients may have 1 guest accompany them to the Ultrasound appointment for pregnancy confirmation.

- No food or beverages in the Ultrasound room.

- Please silence cell phones during your appointment.

- Due to the size of our waiting room, we ask that only the patient and their 1 guest wait in the waiting room prior to their Ultrasound appointment. **Please leave children, additional family members and friends at home during your Ultrasound appointment.**

- If necessary, your guest may be asked to wait outside the exam room in order to accommodate the doctor or staff in conducting exams or procedures. Please notify your guest prior to the appointment that they may be asked to step out of the exam room if necessary.

Patient name:_____

Signature: _____ Date: _____