New Patient History and Physical

Date_____

Name_____ PCP_____

Birth Date_____ Age_____ Referred by_____

What is the reason for today's visit? _____

_____

_____

Menstrual History

Age of first period_____ Date of Last Period_____

Number of days between start of one period and the next____

Number of days of flow____ Are periods regular? Yes/No

Amount of flow Light/Medium/Heavy Are periods painful/crampy? Yes/No

Do you have bleeding between periods? Yes/No After intercourse? Yes/No

Gynecology History (Circle all problems in your past or present history)

Abnormal Pap Date_____ Results_____ Treatment_____

Venereal Warts/ Condyloma Pelvic Inflammatory Disease Chlamydia

Gonorrhea Syphilis Herpes Fluid Retention Breast Soreness

Recurrent Vaginal Infections Recurrent Bladder Infections Urinary Leakage

Ovarian Cysts Endometriosis Fibroid Uterus Infertility PCOS

PMS: Depression/Anxiety

Menopausal Symptoms: Hot Flashes Night Sweats Vaginal Dryness

Sexually Active Yes/No Sexual Problems: Decreased Sex Drive Painful Sex

Breast Problems: History of Cancer Discharge Abnormal Mammogram

Past Biopsy: Date_____ Results_____Implants Reduction

Birth Control Method_____

Medical History (Check all problems in your past or present history)

Chicken Pox ___ Chronic Lung Disease ___ Tuberculosis ___

Asthma ___ Heart Disease ___ Hypertension ___

High Cholesterol ___ Migraines ___ Seizures ___

Stroke ___ Hepatitis/Jaundice ___ Ulcers/Reflux ___

Kidney Stones ___ Diabetes ___ IBS ___

Liver Disease ___ Anemia ___ Thyroid Disease ___

Major Accident ___ Glaucoma ___ Blood Transfusion ___

Cancer ___ Depression/Anxiety ___ Osteoporosis ___

Physician Comments (Office Use Only)

CC: _____

HPI: _____

Review of Systems (Office Use Only)

Constitutional: Weight Loss, Weight Gain, Fevers, Fatigue
Eyes: Contacts/Glasses, Double Vision, Spots Before Eyes, Tunnel Vision
ENT: Earaches/ Ringing, Sinus Problems, Sore Throat/Mouth, Dental Problems
CV: Palpitations, Chest Pain, Difficulty Breathing, Leg Swelling
Respiratory: Wheezing, Spitting up Blood, Shortness of Breath, Chronic Cough
GI: Diarrhea, Nausea/Vomiting, Constipation, Hemorrhoids, Incontinence
Urinary: Blood, Pain, Urgency, Frequency, Incontinence, Incomplete Emptying
Musculoskeletal: Muscle Weakness, Joint Pains, Low Back Pain
Skin/Breast: Breast Pain, Discharge, Masses, Rash, Ulcers, Acne
Neurological: Dizziness, Seizure, Numbness, Trouble Walking
Psychiatric: Depression, Crying, PMS, Sleep Disorder, Eating Disorder
Endocrine: Dry Skin, Abnormal Thirst, Hair Loss, Facial Hair
Hematologic/Lymphatic: Bruising, Enlarged Lymph Nodes, Bleeding
Allergy/Immunologic: Environmental, Food, Immune Disorder

Obstetrical History

Please fill out completely regardless of stage of life, including live births, still births, miscarriages, abortions, and tubal pregnancies.

Date	Pregnancy Length	Labor Duration	Sex	Weight	Delivery Type
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____

Surgical History

Year	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications (Including Vitamins)

Medication	Dosage	Allergies (Medication/Type of Reaction)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Occupation_____

Marital Status: Single/Married/Widow/Divorced

Sexual Preference: Heterosexual/Homosexual/Bisexual

Do you Exercise? Yes/No Type/Frequency_____

Do you Smoke? Yes/No Number per day_____

Do you drink Alcohol? Yes/No Number per week_____

Do you use Recreational Drugs? Yes/No Type_____

Do you wear your seatbelt in the car? Yes/No

Do you have problems with Verbal/Physical Abuse? Yes/No

Do you follow a special diet? Yes/No Type_____

Screening Tests/Vaccines (List most recent date)

Pap Smear_____ Normal/Abnormal

Mammogram_____ Normal/Abnormal

Cholesterol_____ Normal/Abnormal

Colonoscopy_____ Normal/Abnormal

EKG/Stress Test_____ Normal/Abnormal

Bone Density Test_____ Normal/Abnormal

TB Skin Test_____ Normal/Abnormal

Rubella Immunity_____ Normal/Abnormal

Flu Vaccine_____

Pneumonia Vaccine_____

Gardasil Vaccine_____

Family History

Please indicate which family members have the following conditions, past or present.

Ovarian Cancer_____ Heart Disease_____

Breast Cancer_____ Melanoma_____

Uterine Cancer_____ Colon Cancer_____

Mom: Name_____ Alive/Deceased Age_____ Cancer/Heart Disease?

Dad: Name_____ Alive/Deceased Age_____ Cancer/Heart Disease?

Siblings: Name_____ Alive/Deceased Age_____ Cancer/Heart Disease?

Name_____ Alive/Deceased Age_____ Cancer/Heart Disease?

Name_____ Alive/Deceased Age_____ Cancer/Heart Disease?

Name_____ Alive/Deceased Age_____ Cancer/Heart Disease?

Please list any additional issues or comments you would like to address.

_____

_____

_____

_____

Registration and Insurance Information

Patient Information

_____ _____ _____ _____

Last Name First Name M.I. Date of Birth

_____ _____ _____ _____

Address City State ZIP

Marital Status ___Single ___Married ___Divorced ___Widowed ___Separated

Last 4 of Social Security Number: _____

_____ _____ _____

Primary Phone Secondary Phone Email Address

Emergency Contact

_____ _____

Name Phone

Relationship to Patient: _____

Pharmacy Information

_____ _____ _____

Store Name Address Phone Number

Insurance Information

_____ _____ _____

Type of Insurance Policy # Group #

_____ _____ _____

Subscriber Name Subscriber Date of Birth Relationship to Patient

Consent for Use and Disclosure of Your Health Information

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose your health information in our possession.

The use and disclosure by this office are necessary and will be used in connection with your treatment, our obtaining payment for treatment and services that this office provides to you, and so that this office can conduct its health operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please review the Notice of Privacy Practices Form that this office has prepared and is furnishing for you. Please also see our Notice of Privacy Practices Form for a detailed discussion of the meanings of “treatment”, “payment”, and “health care operations”.

You have the right to review our Notice of Privacy Practices Form prior to signing this consent. Please be advised that the Notice of Privacy Practices Form may be revised by this office from time to time. Such revisions of the Notice of Privacy Practices Form will be made available to you by contacting our office manager.

You have the right to revoke this consent at any time. If you wish to revoke this consent, you may do so in writing.

By signing below, you acknowledge that you have read and understand this consent and this office’s Notice of Privacy Practices Form. You further acknowledge that you have received a copy of this office’s Notice of Privacy Practices Form to take with you.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Patient or Legal Representative Date

GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

1) Consent: I, the undersigned patient or authorized representative of the patients, hereby voluntarily request, consent to, and authorize West Oakland OB/GYN and its staff to provide medical care including treatment, examinations, diagnostic procedures, and administration of medication as deemed necessary and advisable by the practice and its healthcare provider to me.

2) Release of information: I hereby authorize the practice to release and to disclose to any third-party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary to receive reimbursement for any healthcare service rendered to me by the practice. I also authorize release and disclosure of my patient records to other healthcare providers who may, in the opinion of the practice, be of assistance in providing treatment or the most appropriate medical care to me.

3) Physician Referral: I understand that if my health insurance is provided by a managed care plan, I am responsible for contacting my primary care physician and obtaining necessary referrals for my services rendered at this office. Failure to do so will result in me being financially responsible for said services.

4) Payment: I understand that I am responsible for any health insurance deductibles and or copayments. I understand that I am financially responsible for the cost of services at the time they are rendered unless prior arrangements have been made. I understand that if my medical insurance plan (or third-party benefit plan) denies payment of services or the services are not covered under such plan, I will be responsible for payment of said services and I agree to pay all charged submitted by the practice for the care given to me. I authorize my medical Insurance plan (or third-party benefit plan) to make payments directly to the practice for any services that are rendered to me.

5) Accuracy & Integrity: I hereby acknowledge the information I provided on the patient registration and patient history forms to be true, correct and completed to the best of my ability.

6) No Guarantees: I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees are made as to the result of the care and treatment which I have hereby authorized.

7) Contact Authorization: I do ___ do not___ (check one) authorize information to be left on my voice mail.

We ordinarily contact you using your phone number and home address. If you want us to contact you in another manner, please provide us with specific instructions about how we can contact you.

_____

I have read this form, or it has been read to me. I understand the entire contents and significance of this form. All my questions (if any) have been answered. Further, I understand that this consent will be deemed continuing, and I am free to revoke my consent at any time.

Patient's name: _____

Patients Date of Birth: _____

Signature of Patient/ Guardian: _____ Date: _____

Relationship to Patient if not signing for self: _____