SOUTHWEST MEDICAL GROUP | FAMILY MEDICINE OBSTETRICS GYNECOLOGY
WOMEN'S AND FAMILY HEALTH
An Affiliate of Southwest Health System

GYNECOLOGY
PATIENT HISTORY FORM
(Confidential)

NOTICE TO OUR PATIENTS

Thank you for choosing us as your healthcare provider. We look forward to providing an office environment and provider relationship that meets you and/or your family's medical needs.

Items to bring to your first appointment:

1. Driver's license or other photo identification.
2. All insurance cards.
3. Co-pays or payment in full at the time of your visit if you are not covered by insurance.
4. Actual bottles of all medications (prescribed and over the counter) that you are currently taking.

No-Show Policy

Our policy is to call patients the business day prior to their scheduled appointment to remind them of the appointment date and time. We perform these calls as a courtesy to our patients and to allow us the opportunity to reschedule the time slot should the appointment not be necessary. A phone call from you to cancel your appointment will allow us to schedule another patient that needs to be seen. Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide **24 hours notice** if you are unable to keep your appointment. This will allow us to call one of our patients on a waiting list to fill the available slot on the schedule.

To improve care for our patients, we will track all "No-Show" visits. Each patient will be allowed to miss two scheduled appointments within a **one year period** without penalty. Once a third appointment is missed, the patient will be at risk of being discharged from the practice or the Southwest Medical Group. To prevent this from happening, patients shall receive a letter each time they no-show for an appointment reminding them of our no-show policy.

For the purposes of this policy, a no-show appointment is defined as follows:

1. An appointment which is missed by the patient without any advance notice.
2. An appointment that is cancelled less than 24 hours prior to the scheduled appointment time.
3. An appointment in which the patient arrives 10 minutes or more beyond the scheduled appointment time.

Due to the check-in process, we request patients arrive 20 minutes prior to their scheduled appointment time to spend their allotted time with their provider.

Failure to show for the initial "new patient" appointment may eliminate your opportunity to establish care as a new patient.

Rx Refill Policy

Our policy is to refill patient prescriptions within 72 (business) hours of receiving the request. Please do not wait until you are completely out of medication or you will likely do without until the refill can be processed.

Patient Name:_____ Date of Birth: _____

Signed (signature required):_____ Date/Time:_____

Patient, Parent or Legal Guardian:_____ Date/Time:_____

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NEW PATIENT / HISTORY INFORMATION - ADULT

Date:_____

Patient Name: _____
First Name Middle Name Last Name

Date of Birth:_____ Age:_____ Gender: Male Female Street

Address:_____City/State/Zip:_____

Mailing Address (if different):_____City/State/Zip:_____

Best Contact Number:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address:_____

Would you like to sign up for our Southwest Medical Group patient portal? ☐ No ☐ Yes

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Social Security #_____-_____-_____Primary Care Physician:_____

Language:_____Race: [American Indian or Alaska Native/ Native American /

African American / Asian / Chinese / Filipino / Japanese / White / Hispanic / Native Hawaiian / Other]

Marital Status: [Single Married Separated Divorced Widowed] Number of Children_____

Occupation:_____ Retired? Y / N

Patient's Employer:_____

Business Address:_____Phone: _____

Name of Primary Insurance:_____Name of Primary Insurance Holder:_____

Member ID#:_____Group #:_____

Name of Secondary Insurance:_____

Member ID#:_____Group#:_____

Patient's Relationship to Insurance Holder:_____

In case of Emergency, who should be notified? Name:_____

Relationship to Patient:_____Contact Phone Number:_____

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Patient Name: _____DOB:_____Today's Date: _____

Reason for Visit: □ GYN Annual Exam □ OB □ Emergency □ Consultation □ Other:_____

Please give more information if needed: _____

GYNECOLOGIC HISTORY

First day of last menstrual period**:** _____ Age (or grade) when periods began:_____

Are your periods usually: □ Regular □ Irregular □ No longer menstruating Date of Menopause: _____

Periods last _____days Periods occur every _____days Bleeding is: □ Heavy □ Moderate □ Light

Do you have bleeding between periods? □ Yes □ No

Do you have cramps/pain with your periods? □ Yes □ No

If yes, do you use pain med? □ Yes □ No

Do you have pain or bleeding with intercourse? □ Yes □ No

Do you use; □ Pads, □ Tampons, □ Both

Are you having problems with your sex drive? □ Yes □ No

Are you currently sexually active? □ Yes □ No

Is your partner: □ Male □ Female □ Both (bi-sexual)

Number of lifetime sexual partners: _____ Number of partners in past year:_____ (for risk factors)

PERSONAL HISTORY

Menstrual Dysfunction		**Lung Problems**		**Cancer**		**Diabetes**	
If yes, what type?		If yes, what type?		If yes, what type and year diagnosed :		**High Cholesterol**	
						High Blood Pressure	
Abnormal Pap Smear		**Heart Problems**		Treatment:		**Bladder Leaking**	
If yes, Treatment?		If yes, what type?		Chemotherapy		**Thyroid Disease**	
				Radiation		**Pituitary Disease**	
STD Exposure		**Liver Disease**		Other		**Hemorrhoids**	
If yes, what type?		If yes, what type?				**Arthritis**	
						Osteoporosis	
Vaginal Problems		**Hepatitis A, B or C**		**Stomach Problems**		**Adult Fractures**	
If yes, what type?				If yes, what type?		**Neck / Back Problems**	
Sexual Dysfunction		**Blood Disorder**		**Dermatology Problems**		**Seizure Disorder**	
If yes, what type?		If yes, what type?		If yes, where?		**Depression**	
						Psychiatric History	
Uterine Fibroids		**Blood Transfusion**					
		If yes, year given:					

Please add other pertinent diagnoses or more information if needed: _____

MEDICATION ALLERGIES: *Please specify reaction*

☐Penicillin ☐Sulfa ☐Codeine ☐Morphine ☐Latex ☐Aspirin ☐Tylenol ☐No Known Drug Allergies

Other_____

Reaction: _____

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IMMUNIZATIONS: *Please check all that are current*

☐Diphtheria/Tetanus (every 10 years) ☐Hepatitis B ☐Hepatitis A ☐MMR (Measles, Mumps, Rubella) ☐Flu (yearly)
☐Varicella (Chicken Pox) ☐Pneumonia ☐Tdap (As adult or with every pregnancy)

FAMILY HISTORY: *Please check the box and write which family member and what side of your family they are on (Maternal or paternal)*

		Family Member(s)			Family Member(s)			Family Member(s)
Breast cancer			High blood pressure			Alzheimer's		
Cervical cancer			Heart Attack			Mental Illness		
Ovarian cancer			Stroke			Other:		
Uterine cancer			Diabetes					
Colon cancer			Osteoporosis					
Other cancer			Thyroid					

SOCIAL AND EMOTIONAL HISTORY:

Tobacco use: ☐ Never
☐ Now: Packs per day:____How many yrs.:_____/☐ Past: Packs per day:____How many yrs?_____Date quit: _____
Alcohol use: Drinks per week:_____Type:_____**Marijuana use**: How much:_____How often: _____
Caffeine use: Quantity per day:_____Type: _____
Do you exercise? ☐ Yes, ☐ No. If yes, how often and what type? _____
Do you have History of Depression? ☐ Yes ☐ No **Anxiety?** ☐ Yes ☐ No
Do you have a History of Abuse? ☐ Yes, ☐ No ☐ Domestic ☐ Sexual If yes, Do you want to discuss? ☐ Yes, ☐ No

CONTRACEPTIVE HISTORY

Current method of birth control: ☐ Vasectomy ☐Tubal ligation ☐Birth Control ☐Diaphragm ☐Foam/Gel ☐Condoms
☐Natural Family Planning/Rhythm ☐Depo Provera Injections ☐IUD: Type:_____ ☐ Nexplanon ☐Nuva Ring ☐None
Have you ever had a problem with any of the above contraceptives? ☐ Yes ☐ No If yes, state which method and what the problem was:_____

CURRENT MEDICATIONS, SUPPLEMENTS, VITAMINS, OR HERBALS:

Med/Sup/Herbal	Dose & Frequency	Med/Sup/Herbal	Dose & Frequency	Med/Sup/Herbal	Dose & Frequency

Preferred Pharmacy:_____**Address (City):**_____

SURGICAL HISTORY

Year	Type of surgery	Reason	Complications

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PREGNANCIES

Total # of Pregnancies: _____ Miscarriages: _____ Abortions: _____ Preterm Deliveries: _____ Term Deliveries _____

Include live, miscarriages and abortions below

Year	Vaginal or Cesarean	# Weeks at delivery	Length of labor	M/F	Birth Weight	Complications

SCREENINGS *Please specify month and year*

Last Pap smear date: _____
Last mammogram date:_____
Last colonoscopy date: _____
Last cholesterol testing date:_____
Last DEXA (osteoporosis screening) date: _____

Is there anything specific that you would like to address today?:

_____

_____

Signature: _____ **Date:** _____

SOUTHWEST HEALTH SYSTEM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: Address:	Phone Number: _____ Date of Birth: _____ Last 4 digits SSN#: _____ (optional)

I, _____, hereby authorize disclosure of my protected health information as follows:

RELEASE FROM:

Facility, Person, Provider: Address:	Phone Number: _____ Fax Number: _____* E-mail: _____ (e-mailed information will be encrypted)

RELEASE TO:

Facility, Person, Provider: Address:	Phone Number: _____ Fax Number: _____* E-mail: _____ (e-mailed information will be encrypted)

***SHS DOES NOT FAX PERSONAL HEALTH INFORMATION TO HOME FAX MACHINES**

Information to be released: From (date) _____ to (date) _____

- ☐ Treatment Records-Hospital
- ☐ Office Visit Notes - Clinic
- ☐ Consultation Reports
- ☐ Other, list below:
- ☐ Laboratory Reports
- ☐ Diagnostic Imaging Reports
- ☐ Operative Reports
- ☐ Emergency Room Records
- ☐ Discharge Summary
- ☐ Ambulance Run Reports
- ☐ History and Physical
- ☐ Pathology Reports
- ☐ Sleep Lab Reports

_____.

Purpose of Release: ☐ Medical Care ☐ Transferring Care ☐ Attorney ☐ Personal Records ☐ Other: _____.

Sensitive Information: I understand by checking any boxes below, I have given permission to release confidential information related to HIV, Mental Health Care, or Drug and Alcohol Treatment, which is protected by federal law 42 CFR Part 2. (If the boxes are not checked, this information will **NOT** be released.)

- ☐ Diagnosis and/or treatment relating to drug or alcohol abuse
- ☐ Diagnosis and/or treatment relating to mental health conditions
- ☐ Diagnosis and/or treatment relating to HIV testing, infection or diagnosis and/or treatment for AIDS

Right to Revoke: I understand that I may revoke this Authorization at any time by notifying Southwest Health System, Inc., in writing. I understand that revocation will not have any effect on actions taken prior to receipt of the revocation.

Expiration: This Authorization will automatically expire 180 days from the date of my signature, unless otherwise specified as follows: _____(date).

Re-Disclosure: I understand that the information used and/or disclosed according to this Authorization may no longer be protected by federal privacy law also known as HIPAA, and the recipient of the health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

With my signature below, I acknowledge and authorize Southwest Health System, Inc., to use and/or disclose my protected health information as described above. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.

Patient name printed: _____ Date of Signature: _____/Time:_____

Patient signature: _____

Patient representative name printed: _____

Patient representative signature: _____/ Relationship to Patient: _____