

Date _____ Name _____ Birth Date _____ Age _____ Race/Ethnicity _____

Phone: Home _____ Work _____ Cell _____ Email _____

Preferred Pharmacy: Name: _____ Address _____ Phone _____

Is there someone we can thank for referring you? _____ Primary Care Physician _____

Circle your RWG Physician: Meritt Collins Neyman Mills Montalvo Garza Loar Smith

Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ALL of the following questions completely.

REASON FOR YOUR VISIT (give details as needed) _____

PAST MEDICAL HX

Date of last Annual Exam _____ Date/Type of last Labwork: _____ Date of Last Pap Smear _____

Have you had an Abnormal pap smear? _____ List dates & treatment _____

Date/ Results of last Mammogram _____

Date/ Results of last Colonoscopy / flexsigmoidoscopy _____

Date/ Results of last Bone Density scan? _____

Have you ever had a Blood Transfusion? (List date/reason) _____

Would you accept blood or blood products in case of an emergency? _____ If not, please explain _____

Did your mother receive a drug called DES when she was pregnant with you? _____

Do you have an advanced directive? _____

REPRODUCTIVE HISTORY

Age at 1st period _____ How far apart are your cycles (ex.28days) _____ How many days do you bleed (i.e. 5days) _____

*Flow: light medium heavy clots Symptoms: cramps pelvic pain headaches mood changes

Date your last period started _____ How certain are you: Very Somewhat Not at all

Current Birth Control Method (i.e. condoms, birth control pills/ring/patch, IUD, menopause, Hysterectomy) _____

Do you desire a change? _____

Are you Menopausal: N/A Yes No Age at Menopause: _____ Are you on hormones? Type? _____

Total # of pregnancies: _____ # of Term Deliveries (after 36weeks) _____ # of Preterm Deliveries (before 36weeks) _____

How many Cesarean Sections _____ How many Living Children _____

Abortions (please list approximate year) _____

Miscarriages (please list approximate dates & weeks of pregnancy) _____

Ectopics (list dates, weeks of pregnancy, treatment): _____

Pregnancy or Delivery Complications: _____

SURGICAL HX

Please list any surgeries or hospitalizations you have undergone (D&C, Hysterectomy, Cesarean Section)

Year of Surgery Type / Reason for MD Hospital

Meds &

List Drug Allergies (and the Reaction you had):

List Medications (include over-the-counter & supplements), Doses, the Reason you are taking, and Who prescribed it:

PERSONAL & FAMILY HISTORY (PLACE AN "X" IN THE WHITE BOXES THAT APPLY)

PATIENT PAST MEDICAL HX & FAMILY HX

	You	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or Sisters	Children	OTHER family members
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida...)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (i.e. ITP, sickle cell)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine/Endometrial										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis...)										
Glaucoma										
Heart disease or Mitral valve prolapse										
High blood pressure										
High cholesterol										
Kidney disorder/disease										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disorder										
Uterine anomalies										
...Still Living?	X									
...Deceased at Age?	----									

OTHER DISEASES/ILLNESSES:

SOCIAL HISTORY

Marital Status (please check one):

Single/Not Dating Married
 Single/ Dating Divorced
 In a committed relationship Widowed
 Engaged

Safety: Do you feel safe in your current relationship: Yes No
 If not please explain _____

Have you ever been physically abused in a relationship: Yes No
 If so, please explain _____

Have you ever had an unwanted sexual encounter: Yes No
 If so, please let us know when this occurred: _____

Substance Use:

Do you drink alcohol: Yes No
 How many drinks per day or week: _____
 Do you currently use any illicit drugs: Yes No
 Type _____
 How often _____
 Do you smoke cigarettes: Yes No
 How many per day _____
 How long have you been a smoker: _____

Occupation: _____

Do you Exercise: Yes No
 Type _____
 How often _____

Infection Risk:

Have you ever been sexually active? Yes No
 Are you currently sexually active? Yes No
 Sexual preference (circle one): Heterosexual Lesbian Bisexual Other
 How many sexual partners in the last 1 year? _____
 In your lifetime: 1-5__ 5-10__ 10-20__ 20+__

 Have you ever had a sexually transmitted disease (STD)? Yes No
 Hepatitis (Type?) _____
 Syphilis (when? treated?) _____
 Chlamydia (when? treated?) _____
 Gonorrhea (when? treated?) _____
 Genital Herpes (taking meds?) _____
 HPV (human papilloma virus) _____
 Genital warts? _____

...see next page regarding STD testing

PRINT NAME HERE: _____

CENTRAL TEXAS OB/GYN ASSOCIATES
PATIENT AUTHORIZATION FORM

Please read, initial, and sign below

(Initial)_____ FINANCIAL RESPONSIBILITY: I understand that I am ultimately responsible for payment on my account. Payment is expected at the time of service. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles. Claims will be filed for PPO and HMO participants, Medicare and Medicaid. Payment of benefits will be made directly to Central Texas OB/GYN Associates. I understand and accept that by paying with a check, I expressly authorize CTOA (through Chexpedia), to electronically debit my checking account for the amount of the check plus a processing fee of \$30, if my check is dishonored or returned for any reason. I also understand that if I do not pay all of the charges due from me and my past due account is sent to an outside collection agency, an additional fee equal to the collection agency's commission will be added to my outstanding balance.

(Initial)_____ INSURANCE COVERAGE: I understand that I am responsible for providing my physician with any and all insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information. (_____ Staff Initials)

(Initial)_____ LABORATORY FEES: I understand that my physician uses Clinical Pathology Laboratory (CPL). CTOA cannot guarantee my insurance will cover any lab/pathology performed at or ordered by my physician. If my insurance requires use of a different lab, I understand it is my responsibility to inform my physician for proper handling.

(Initial) I DO_____ I DO NOT_____ CONSENT to necessary examinations and/or treatments performed and prescribed by my physician, nurse practitioner or physician's assistant as is necessary in his/her judgment, with patient approval. **Separate consent forms will be signed for procedures performed in the physician's office.**

(Initial)_____ RELEASE OF INFORMATION: I do hereby authorize my physician to release information to the hospital facility in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

(Initial)_____ HIPAA: I acknowledge that I have received or have access to a copy of CTOA's Notice of Privacy Practices.

(Initial)_____ FEE FOR FORMS COMPLETION: I understand that I will be responsible for paying \$15 for forms completion by my physicians or staff. (Example: Disability forms, FMLA forms, etc.)

(Initial)_____ FEE FOR 'NO SHOW'. I understand that a \$25 'no show' fee will be assessed for appointments that I do not keep.

Spouse's Name: _____ Spouse's Work Phone: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Emergency Contact: _____ Emergency Phone: _____
(other than spouse)

Your signature: _____ **Today's date:** _____