RENAISSANCE WOMEN'S GROUP

Patient History (NOB)

Date ________________Name ____________________________________ Birth Date ____________ Age _____ Race/Ethnicity _______________

Phone: Home_________________ Work___________________ Cell _________________ Email _______________________________________

Is there someone we can thank for referring you? __________________________________ Primary Physician ______________________________

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

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 (details if necessary) :____

PAST MEDICAL

Date of last **Annual Exam**______________ Date of Last **Pap Smear** ____________________

Have Paps ever been Abnormal? ________ When & did you receive any treatment_______________________________________

Have you ever had a **Mammogram**?__________ Any Abnormalities?____

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**?____

Have you ever had **Chicken Pox**? ___________________________________

Have you ever had complications with **Anesthesia** of any kind? Please explain____

REPRODUCTIVE HISTORY

How far apart are your menstrual cycles (ex.28-30days) ______________ How many days do you have bleeding (i.e. 5-7 days) ______________

When was the FIRST day of your **last period**? ___________________ How **certain** are you: ◻ Very ◻ Somewhat ◻ Not at all

DATE you got your **first POSITIVE pregnancy test**? _____________________ Was the test done at: ◻ Home ◻ Clinic ◻ an MD office

Were you **desiring pregnancy**? ◻ YES ◻ NO ◻ UNSURE____

Were you using any form of birth control at the time you got pregnant?__________ (If YES, what type: ________________________________)

Total # of pregnancies ______ Total # of live children ______ # of Abortions (list dates)_____________________________________

Miscarriages or Ectopics (list dates & how far along you were): ____

Date of Delivery	# Weeks Pregnant	Hours in Labor	Birth Weight	Sex & Name	Delivery Type	Anesthesia Type	Location	Complications (i.e. preterm labor)

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 / Allergies

List **Drug Allergies** (and the Reaction you had):

____
____
____
____
____
____
____

List **all medications** (include over-the-counter and supplements), **Doses**, the **Reason** you are taking, and **Who prescribes** it:

____
____
____
____
____
____

PATIENT PAST MEDICAL HX & FAMILY HX

PERSONAL & FAMILY HISTORY (please place an "X" in the *WHITE* boxes that apply)

	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 (ex. ITP, sickle cell…)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis…)										
Glaucoma										
Heart disease or MVP										
High cholesterol										
High blood pressure										
Kidney Disease/stones										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disease										
Uterine anomalies										
…Still Living?	X									
…Deceased at Age?	----									

OTHER DISEASES/ILLNESSES:

SOCIAL HISTORY

Marital Status (please check one):
_____Single/Not Dating _______Married
_____Singe/ Dating _______Divorced
_____In a committed relationship _______Widowed
_____Engaged

PARTNER'S NAME: ________________________ **Age:**_______

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:
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?) _______________________________________
Syphillis (when? treated?) __________________________________
Chlamydia (when? treated?) _________________________________
Gonorrhea (when? treated?) _________________________________
Genital Herpes (taking meds?) _______________________________
HPV (human papilloma virus) ________________________________
Genital warts? ____
OTHER ____

PRINT NAME HERE: ____

REVIEW OF SYMPTOMS

Constitutional:	Circle One:		
Frequent Fatigue	Current	Past	N/A
Excess weight gain	Current	Past	N/A
Excess weight loss	Current	Past	N/A

Eyes, Ears, Nose, Mouth:	Circle One:		
Frequent or severe headaches	Current	Past	N/A
Frequent lightheadedness	Current	Past	N/A

Breasts:	Circle One:		
Lumps	Current	Past	N/A
Pain	Current	Past	N/A
Swelling	Current	Past	N/A
Nipple discharge	Current	Past	N/A

Cardiovascular:	Circle One:		
Chest pain	Current	Past	N/A
Fainting	Current	Past	N/A
Swollen/Painful varicose veins	Current	Past	N/A
Calf pain	Current	Past	N/A

Respiratory:	Circle One:		
Frequent shortness of breath	Current	Past	N/A
Frequent Hoarseness	Current	Past	N/A

Gastrointestinal:	Circle One:		
Nausea/ Vomiting	Current	Past	N/A
Frequent Diarrhea	Current	Past	N/A
Frequent Constipation	Current	Past	N/A
Frequent Heartburn/ reflux	Current	Past	N/A
Abdominal Pain	Current	Past	N/A
Blood in stool	Current	Past	N/A
Hemorrhoids	Current	Past	N/A

Genitourinary:	Circle One:		
Urgency	Current	Past	N/A
Frequency	Current	Past	N/A
Pain with urination	Current	Past	N/A
Blood in urine	Current	Past	N/A
Frequent Urine leakage	Current	Past	N/A
Pain with intercourse	Current	Past	N/A
Genital sores	Current	Past	N/A

Genitourinary (continued)	Circle One:		
Irregular periods	Current	Past	N/A
Painful periods	Current	Past	N/A
Heavy periods	Current	Past	N/A
No periods	Current	Past	N/A
Possible pregnancy?	Current	Past	N/A
Abnormal vaginal discharge	Current	Past	N/A
Significant PMS	Current	Past	N/A

Integument (skin):	Circle One:		
New skin lesions	Current	Past	N/A
Changes to moles/skin lesions	Current	Past	N/A

Musculoskeletal:	Circle One:		
Joint pain	Current	Past	N/A
Joint swelling	Current	Past	N/A
Recent back pain	Current	Past	N/A

Endocrine:	Circle One:		
Excess bodily hair growth	Current	Past	N/A
Excess hair loss	Current	Past	N/A
Cold intolerance	Current	Past	N/A
Heat intolerance	Current	Past	N/A
Acne	Current	Past	N/A
Thyroid abnormalities/ treatment?	Current	Past	N/A

Psychiatric:	Circle One:		
Frequent Anxiety	Current	Past	N/A
Frequent Depression	Current	Past	N/A
Suicidal thoughts	Current	Past	N/A
Psychiatric treatment	Current	Past	N/A

Hematologic/Lymphatic:	Circle One:		
Easy bleeding	Current	Past	N/A
Easy bruising	Current	Past	N/A

List any other symptoms bothering you today: ____
____
____

YOUR HEIGHT: _________ **YOUR WEIGHT**: _________

PRINT NAME HERE: ____

PATIENT SIGNATURE: ________________________________ **DATE COMPLETED**: ____________________

RENAISSANCE WOMEN'S GROUP, PA

Genetic Screening Questionnaire

NAME: ___________________________________

Will you be 35 years old or older at your due date?	Y	N
Are you or your baby's father of…		
• Jewish background?	Y	N
• Black/African background?	Y	N
• Mediterranean background?	Y	N
• Asian background?	Y	N
• French-Canadian background?	Y	N
Have you…		
• taken any medications (prescribed or OTC) during this pregnancy?	Y	N
• had any alcohol (beer, wine or hard liquor) during this pregnancy?	Y	N
• used any illegal/street drugs (cocaine, marijuana) during this pregnancy?	Y	N
• taken Accutane, blood thinners, or lithium since your last period?	Y	N
• had radiation therapy or chemotherapy since your last menstrual period?	Y	N
• take mega dose vitamins, especially vitamin A since your last period?	Y	N
Do you or your baby's father have epilepsy?	Y	N
• and take medication? If yes type_____________________________	Y	N
Do you have diabetes or have you had diabetes with pregnancy and are/were you….	Y	N
• on insulin	Y	N
• on oral hypoglycemic medications	Y	N
• controlled by diet	Y	N
Are you and the father of your baby first cousins or closer?	Y	N
Have you had…		
• three or more miscarriages?	Y	N
• had a stillborn infant?	Y	N
• a child that died within the first year of life?	Y	N

Have you, the father of your baby, or anyone in either family ever had a child	**self**	**father**	**family**
• with Down Syndrome or other chromosomal abnormality?	Y N	Y N	Y N
• with mental retardation?	Y N	Y N	Y N
• with an open spine (spina bifida), skull defect, or anencephaly?	Y N	Y N	Y N
• with a heart defect?	Y N	Y N	Y N
• with a muscle or neuromuscular disease (muscular dystrophy)?	Y N	Y N	Y N
• with Cystic Fibrosis?	Y N	Y N	Y N
• with Hemophilia, sickle cell, thalassemia, or other blood disorder?	Y N	Y N	Y N
• with any birth defect or genetic disease not listed above?	Y N	Y N	Y N

***Patient signature*____*Date*______________**

RENAISSANCE WOMEN'S GROUP
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 Renaissance Women's Group.

(Initial)______INSURANCE COVERAGE: I understand that I am responsible for providing RWG 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. *(______ RWG Staff Initials)*

(Initial)_______LABRATORY FEES: I understand that RWG uses Clinical Pathology Laboratory (CPL). RWG cannot guarantee your insurance will cover any lab/pathology performed at or ordered by RWG. If my insurance requires use of a different lab, I understand it is my responsibility to inform RWG 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 Renaissance Women's Group to release information to North Austin Medical Center (NAMC) or St. David's Medical Center 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 a copy of RWG's Notice of Privacy Practices.

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

(Initial)_______FEE FOR 'NO SHOW'. I understand that a $25 'no show' fee will be accessed 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)

Patient Name: ______________________________ Signature: ____________________________________

Today's date: ___________________ Revised 5/10

Renaissance Women's Group

(OB)

12201 Renfert Way Austin, Texas 78758

Patient Name:	**Appointment Date:**	**Today's Date:**

Please bring this completed form with you to your next appointment

We are pleased you have chosen Renaissance Women's Group and look forward to providing consistent high quality medical care and related services to you. To avoid confusion about your insurance coverage we ask that you contact your insurance company prior to your next appointment to understand your specific plan benefits and coverage. Please be aware that we will bill you privately for any charges not covered by your plan, so time taken now on your part will eliminate unexpected expenses to you later. **This form is to be used as a guide when calling your insurance company regarding your benefits.**

Name of Insurance Company	**Insurance Phone number for benefits**	**Insurance representative spoke with:**
Insurance policy holder's name: ______________________ **Policy holder's date of birth:** - - 19___ ___	**Policy holder's Social Security #:** ________- ________ -__________	**Policy holder's employer's name:** ______________________ **Policy Effective Date:** ________-________-________

To find out if RWG is a participating provider on your plan, give the insurance representative our Tax ID # 74-2760437

1). **What type of plan do I have?** ____HMO ____PPO ____POS ____Managed Care ____Indemnity

Verify with your insurance that the doctor that you are scheduled with is a contracted provider (IN NETWORK) for your type of policy. If you are seen by a physician at RWG and you are out of network, you will be responsible for the payment of these services to RWG. Please be aware that RWG may be contracted with your insurance but not for your plan type. For example, we are contracted with Cigna PPO but we are not contracted with Cigna HMO, POS and Managed Care.

2). **Is Clinical Pathology Labs an IN-NETWORK Lab (Tax Id 74-2554159)?** ____YES ____NO…if not, **what lab is in-network**____________

3). Do I have **OB GLOBAL (antepartum, delivery and postpartum visit) maternity benefits**? ____YES ____NO

If so, how is it covered? ____100% ____90% ____80% or ____________________________

Do I have a deductible to meet? ____YES ____NO If YES, deductible amount? $______ What is met?______

The percentage that your insurance does not cover will be DUE to RWG by your second OB visit

4). **Does my delivery require pre-certification for my delivery?** ____YES ____NO

If so, what is the **phone number** to call to obtain the pre-certification? ______________

5). **Do I have coverage for all Ultrasounds done during my pregnancy?** ____YES ____NO

If so, coverage? ________________

Is a referral or authorization required? ____YES _____NO

6). **Is North Austin Medical Center an in-network hospital on my plan (Tax Id 74-2781812)?** ____YES ____NO

7). Does my policy cover **permanent sterilization (tubal ligation)?** ____YES ____NO

8). Is **Circumcision** covered by my plan? ____YES ____NO

If so, is **pre-certification** required for circumcision? ____YES ____NO

If so, what is the phone number to call? _______________________

If at any time, while you are a patient at **Renaissance Women's Group**, you change your PCP, insurance plan, or are informed of contract change, it is your responsibility to immediately inform our business office.

-THANK YOU –

Revised 12/08