

HISTORY FORM

Legal Name _____ **Date of Birth** ____/____/____

Previous last names _____

Race: ___White ___Black/African American ___American Indian ___Asian Other_____

Ethnic background: ___Hispanic or Latino ___Not Hispanic or Latino ___Declined Other_____

Any cultural or religious beliefs that may affect your medical care? _____

Emergency contact(s) name _____

Address & phone number of emergency contact _____

Your preferred Pharmacy Name, Address and Phone Number: _____

Reason for office visit today: _____

Date of Last Pap Smear ____/____/____

Date of Abnormal Pap Smear ____/____/____

Please provide approximate dates of any previous radiological examinations from the list below:

Mammogram ____/____/____ Bone density ____/____/____ Colonoscopy ____/____/____

Have you had any of the following immunizations/vaccines:

___MMR (Measles/Mumps/Rubella) ___Gardasil ___Tetanus booster ___Meningitis

Have you had the Chicken Pox or been vaccinated for it? _____

Please list any medical conditions you may have (asthma, diabetes, hypertension, STD's, etc.):

Please list any surgical procedures/operations you have had and the dates they were performed:

Date

Operation

FAMILY HISTORY

List any family members (blood relatives only) with the following medical problems (list relationships, ie mother (M), father (F), sister (S), brother (B), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM), paternal grandfather (PGF), etc.)

CARDIAC

Stroke _____
Heart disease _____
High blood pressure _____
High cholesterol _____
Blood clots _____
Pulmonary embolism _____

NEOPLASMS/MALIGNANCY

Ovarian cancer _____
Uterine cancer _____
Breast cancer _____
Colon cancer _____
Other malignancy _____
Cervical cancer _____

DIGESTIVE/GASTROINTESTINAL

Celiac disease _____
Colon polyps _____
Familial polyposis _____
Ulcerative colitis _____
Crohn's disease _____
Hepatitis _____

NEUROLOGIC

Alzheimer's disease _____
Parkinson's disease _____
Seizure disorder _____

ENDOCRINE

Diabetes (sugar) _____
Thyroid disorder _____
Graves disease _____

PSYCHIATRIC

Bipolar disorder _____
Depression _____
Schizophrenia _____
Alcoholism _____

HEMATOLOGIC

Factor VIII disorder _____
Von Willebrand's disease _____
Sickle cell disease/trait _____
Hereditary spherocytosis _____

RESPIRATORY

Tuberculosis _____
COPD _____
Emphysema _____
Lung Cancer _____

MUSCULOSKELETAL

Arthritis _____
Osteoporosis _____
Osteopenia _____

OTHER

Cystic fibrosis _____
Scleroderma _____
Lupus _____

SOCIAL HISTORY:

Do you ever drink alcohol? Yes/No How often on average? _____ How many drinks per time? _____
Have you ever smoked? Yes/No How many years? _____ How many per day? _____ When did you quit? _____
Do you use any other non-prescription drugs? Yes/No If yes, what type? _____
How old were you when you had sex for the first time? _____
How many sexual partners have you had in your lifetime? (circle one) 0 – 1 2 – 5 More than 5
Last grade completed? _____ Did you attend college? Yes/No
How did you find out about or choose us? (circle) Physician Friend Azalea Website WCTV HealthLinks
Billboard Yellow Pages TV Commercial Newspaper Other _____
What is your occupation? _____
What is your marital status? (circle) Single Dating Engaged Married Divorced Widowed

OFFICE ONLY: Height ____' ____" Weight _____ BP ____ / ____ HGB ____ U/A ____ Temp ____ G ____ P ____

NOTES:

Azalea Women's Healthcare

Patient Information

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

City, State, Zip: _____

Alt. Phone: _____

Date of Birth: ____/____/____ Age: _____

Marital Status: () Single () Married () Divorced

Social Security # ____ - ____ - ____

Race: () Black/African American () White
() Other _____ () Declined

Driver's License # _____

Ethnicity: () Hispanic () Non-Hispanic

Patient Employment

() Employed () Retired () Unemployed

Employer: _____

Emergency Contact

Name: _____

Phone #: _____

Responsible Party (If other than patient)

Name: _____

Employer: _____

Address: _____

Work Phone: _____

City, State: _____

Alternate Phone: _____

Date of Birth: ____/____/____

Social Security # ____ - ____ - ____

Primary Insurance Check One. () BCBS () CHP () Vista () MCR () MCD () Other _____

Policy Holder : _____

Relationship to Patient: _____

Insurance Co: _____

Policy ID # _____ Group # _____

Policy Holder Date of Birth: ____/____/____

Policy Holder SS # ____ - ____ - ____

Medicare Secondary Insurance () Same as Patient () Same as Guarantor

Policy Holder: _____

Relationship to Patient: _____

Insured Phone: _____

Social Security # ____ - ____ - ____

Insurance Co: _____

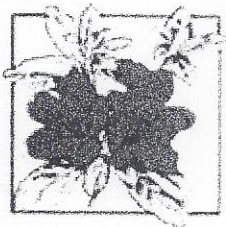
Policy ID # _____ Group # _____

I, the below signed patient, certify that the above information is correct and understand that if any information is incorrect, I will be financially responsible for all costs incurred from the visit. I understand that Azalea Women's Healthcare will file my insurance as required by contracts, where applicable, and that I am responsible for full payment to Azalea Women's Healthcare for services provided. Furthermore, I authorize Azalea Women's Healthcare to release pertinent medical records for documentation of services in order to process medical insurance claims.

Signature _____

Date ____/____/____

AZALEA WOMEN'S HEALTHCARE



CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

_____, herein after referred to as **PATIENT**, hereby consents to the use or disclosure of his/her individually identifiable health information (Protected Health Information or PHI) by Azalea Women's Healthcare, herein after referred to as **FACILITY**, in order to carry out treatment, payment, or health care operations. The patient should review the **FACILITY'S** Notice of Privacy Practices for **PHI** for a more complete description of the potential uses and disclosures of such information, and the **PATIENT** has the right to review such Notice prior to signing this consent form.

The **FACILITY** reserves for itself the right to change the terms of its Notice of Privacy Practices for **PHI** at any time. If **FACILITY** does change the terms of its Notice of Privacy Practices, **PATIENT** may obtain a copy of the revised Notice by contacting Adrienne George, MD, **PRIVACY OFFICER** at (850)877-5767.

PATIENT retains the right to request that the **FACILITY** further restrict how his/her **PHI** is used or disclosed to carry out treatment, payment, or health care operations. The **FACILITY** is not required to agree to such requested restrictions; however, if the **FACILITY** does agree to **PATIENT'S** requested restriction(s), such restrictions are then binding on the **FACILITY**.

At all times, **PATIENT** retains the right to revoke this Consent. Such revocation must be submitted to the **FACILITY** in writing. The revocation shall be effective except to the extent that the **FACILITY** has already taken action in reliance to the Consent.

The **FACILITY** may refuse to treat **PATIENT** if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the **FACILITY** is required by law to treat individuals). If **PATIENT** (or authorized representative) signs this Consent form and then revokes Consent, the **FACILITY** has the right to refuse to provide further treatment to **PATIENT** as of the time of revocation (except to the extent that the **FACILITY** is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT, TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATE TERMS. I HAVE ALSO RECEIVED A COPY OF THE NOTICE OF PRIVACY POLICIES FOR MY REVIEW AND RECORD.

Date: _____ Time _____ AM/PM

Signature of Patient

*Authorized Representative Signature
& Relationship to Patient*

Please Print Name

Please Print Name

OBSTETRIC HISTORY

Name _____

Date _____

1. Date of first day of last menstrual period: ____/____/____ Was this a normal period? __ yes __ no
2. What day did you have your first positive pregnancy test (including a test done at home)? ____/____/____
3. What was your weight before you got pregnant? _____
4. Have you had any vaginal bleeding or cramping? __ yes __ no
5. Have you been exposed to x-rays or drugs since your last menstrual period (LMP)? __ yes __ no
6. Have you felt the baby move yet? __ yes __ no
If so, what was the first day you felt movement? _____
7. Have you ever smoked? __ yes __ no
If so, how many years? ____ How many per day? ____ When did you quit? _____
8. Do you ever drink Alcohol? If so, how much? _____ __ yes __ no
9. Do you use any street drugs or have you used them in the past? __ yes __ no
If so, what and when? _____
10. Do you take any medications, drugs, or herbal therapies? __ yes __ no
Please include prenatal vitamins, iron, over-the-counter medications, and "natural" products.

11. Do you or your partner have a history of herpes or any other sexually transmitted disease? __ yes __ no
If so, what? _____
12. Have you ever had diabetes or thyroid disease? __ yes __ no
13. Have you ever had high blood pressure or heart disease (including heart murmur)? __ yes __ no
14. Have you ever had chicken pox or have you been vaccinated for it (varicella vaccine)? __ yes __ no
15. Will you be less than 15 or more than 35 years old when your baby is born? __ yes __ no
16. Are you or your partner Black, Mediterranean, or Asian? __ yes __ no
17. Are you Jewish? If yes, are you of Central or Eastern European background? (circle) __ yes __ no
18. Have you, your family, your baby's father's family, or any blood relative had:
 - a. Cerebral palsy or epilepsy? __ yes __ no
 - b. Down's syndrome (mongolism) or mental retardation? __ yes __ no
 - c. Spina bifida or meningomyelocele (open spine) or hydrocephalus (water head)? __ yes __ no
 - d. Hemophilia or bleeding disorders? __ yes __ no
 - e. Muscular dystrophy? __ yes __ no
 - f. Cystic fibrosis? __ yes __ no
 - g. Other inherited disorders? __ yes __ no
 - h. Any babies been born in your family or your baby's father's family with any problems? __ yes __ no
If so, what? _____
19. Have any women in your family (your blood relatives) had any problems having babies? __ yes __ no
If so, who and what. _____
20. Do you have a history of infertility, miscarriage, stillbirth, or any serious pregnancy complications? __ yes __ no
If so, what. _____
21. Do you feel safe in your home? __ yes __ no
22. Have you had any blood tests or ultrasounds during this pregnancy? __ yes __ no
If so, when & where. _____