STATESBORO WOMEN'S HEALTH SPECIALISTS

Gary B. Sullivan, MD, FACOG Lisa S. Rogers, MD, FACOG Barbara B. Williams, DO, FACOG
1523 Fair Road/ PO Box 1958, Statesboro, GA 30459 Phone: 912-871-2000 Fax: 912-871-2500

Patient Registration

Patient: _____Today's Date: ____/____/____
Address: _____City: _____State: _____Zip:_____
Home #: _____Work#: _____Cell #:_____
Email: _____Drivers License State: _____Number: _____
Race: _____Religion: _____Preferred Communication: __Email __Patient __Portal __Phone __Text
Marital Status: __Single Married __Partnered __Widowed __Separated __Divorce
Primary Physician:_____ Preferred Pharmacy: _____

Patient's Information

Name: _____
Birthday: _____
Social Security #: _____
Employer: _____
Occupation: _____
Work #: _____

Spouse's Information

Name:_____
Birthday:_____
Social Security #: _____
Employer: _____
Occupation:_____
Work #:_____

Person Responsible for the Bill

Name: _____
Mailing Address: _____
City: _____State: _____Zip:_____

Employer: _____
Occupation: _____
Work #: _____Primary #:_____

Insurance Information

Primary Insurance:_____
Subscriber's Name:_____
Patient's Relationship: Self:__ Spouse: __other: __
Social Security #:_____
Subscriber's Birthday:_____
Subscriber's Employer: _____
Group #: _____ID#:_____

Secondary Insurance: _____
Subscriber's Name: _____
Patient's Relationship: Self: __ Spouse: __ other: __
Social Security #: _____
Subscriber's Birthday: _____
Subscriber's Employer: _____
Group #: _____ID#: _____

Other information

***In case of emergency, local friend or relative to be notified (not living at the same address):
Name: _____ Relationship to the Patient:_____
Home #: _____Work#: _____Cell #:_____

Assignment and Release: I hereby authorize my insurance and/or government benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information, including medical records, required to obtain payment.

Signed: _____ Date: ____/____/____

STATESBORO WOMEN'S HEALTH SPECIALISTS

Please mark which Doctor you prefer to see.

___Gary B. Sullivan, MD, FACOG ___Lisa S. Rogers, MD, FACOG ___Barbara B. Williams, DO, FACOG

Type if Insurance:_____ Type of Appointment:_____

Mail or fax to: PO Box 1958, Statesboro, GA 30459 Phone: 912-871-2000 Fax: 912-871-2500

RELEASE AND/OR OBTAIN MEDICAL INFORMATION AUTHORIZATION

Patient name: _____ DOB:____/____/____
SSN: _____ Maiden name (if applicable):_____
Patient contact number - Home: _____Work: _____Cell:_____

1. I give my permission for Statesboro Women's Health Specialists:
   _____To release medical information to: _____To obtain medical information from:

Name of Facility:_____
Address: _____
Phone: _____Fax: _____
Specific information (if applicable): _____

2. I consent only to the release of information specifically name about and only to the specific person or agency named above.
3. I understand that I may withdraw my permission for the use of this information at any time except to the extent that it has already been used as previously authorized to take action on my behalf. In all cases, any consent given hereby shall have a duration no longer than that reasonably necessary to effectuate the purpose for which said consent is given. If I do not later withdraw this permission, it is my understanding that it will automatically expire in (60) days from the date of signature.
4. I am aware and specifically waive any privilege regarding the following information, which may or may not be contained in these records:

a) Communication made by me to a Psychiatrist (O.C.G.A. section 24-9-21).
b) Communication made by me to a Licensed Applied Psychologist (O.C.G.A. section 43-39-16).
c) Medical information concerning drug dependency (O.C.G.A. section 25-5-17).
d) Medical information concerning alcohol and drug dependency (O.C.G.A. section 37-7-166).
e) Medical information concerning mental retardation (O.C.G.A. section 37-4-125).
f) Medical information concerning alcohol and drug abuse (42CFR, part 2).
g) Medical information concerning Acquired Immune Deficiency Syndrome (AIDS).

Patient/Authorized Person Signature: _____ Date: ____/____/____

Relationship of Authorized Person: _____ Witness Signature: _____

The information released per this authorization has been disclosed from records protected by State and Federal confidentiality statutes. These statutes prohibit further disclosure of this information without the specific written consent of the patient.

STATESBORO WOMEN'S HEALTH SPECIALISTS

Practice Policies

Appointment Policies

- All appointments are scheduled in advance. We do not allow walk-ins. Same day problem appointments are almost always available.
- Please be on time. If you are 15 minutes late, your appointment is subject to be rescheduled.
- Please call if you cannot keep your appointment. Recurrent missed appointments are grounds for dismissal from our practice.
- Physician, office, and patient emergencies impact schedules and result in unpredictable waiting times. We make every effort to maintain our schedule and minimize any inconvenience to you. However, emergencies do occur. If a significant delay occurs, we will inform you and we will gladly reschedule your appointment if you would prefer not to wait.
- Patients are taken back in the order of the appointment time, not the arrival time. Also, some patients may be scheduled for multiple tests so they may be taken back in a different order.

Professional Policy

- Our staff strives to be courteous at all times. If you feel you have received poor customer service, please notify the Office Manager.
- Being rude or threatening to our staff is grounds for dismissal from the practice.
- Please be courteous and not use your cell phone while in our practice. Cell phones interfere with the functioning of certain equipment and may contribute to delays.

Prescription and Forms

- For prescription refills, please call your pharmacy and they will contact us. Please allow 3 days from the date of request. We will only notify you if there is a problem with your request.
- Please allow up to one week for completion of disability forms. There is a $10.00 charge for this service and must be paid when you pick up the forms.
- There is a fee of up to $0.97 per page for copying medical records in their entirety. This must be paid in advance.
- Our physicians rarely call in medications. We believe that by seeing you in the office, we can provide better care.

Expectations and Behaviors

- You are responsible for the behavior of all guests you bring to our office, including your children.
- Children should not be left unattended in the waiting room or exam room.
- Children should not play on or with the furniture.
- Drinks and food are not allowed in our office.

Phone Call Policy

- Our physicians are available for urgent medical matters after office hours.
- Please do not call us regarding refills, forms, billing, etc after hours.
- When you call the office for medical advice, a nurse will call you back or forward a message to one of our physicians. These calls are handled in order of medical importance first. If you do not want to wait for a call back, we suggest you schedule an appointment for us to see you. We handle these calls as quickly as possible, however, it may take up to 24 hours for a nurse to return your call.

Ultrasounds

- Ultrasounds are performed for medical necessity. in pregnancy, we generally perform 3 routine ultrasounds:
  8-10 weeks----dates
  18-20 weeks---anatomy
  34-36 weeks—"estimated fetal weight
- We offer a free 4D ultrasound at 24-26 weeks. The 4D ultrasound is scheduled during your GTT (Glucose Tolerance Test) appointment. There is no charge for this service but it is only attempted ONCE.
- Any ultrasounds that are not medically necessary but are requested by the patient (such as for sex check or another 4D) will incur a fee. For a sex check ultrasound the fee is $69.00. For a 4D ultrasound the fee is $150.00. These fees must be paid in full prior to the ultrasound being performed.

Referrals

- Occasionally we do refer our patients to other physicians. We make every effort to accomplish this in a timely manner. If you have not been notified about your referral appointment within one week, please contact our office.

I agree to adhere to the above financial and office policies. By signing below, I accept the terms and conditions of these policies.

_____ _____

Patient/Responsible Party Signature Date

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Financial Policies

Please place your initials by each of the statements below to designate that you have read and understand the financial policies of this practice.

_____For your convenience, we have an in-house laboratory service. GenPath Women's Health is the laboratory the providers perfer to utilize. With GenPath, they accept, and bill all insurances, and they treat every patient as In Network. It is GenPath's policy to hold patients financially harmless in the event of non-payment by a patient's third party insurance company. I understand that **I am responsible** for notifying Statesboro Women's Health Specialists if I need my blood work or cultures sent to a different lab.

_____I understand that I am responsible for determining if Statesboro Women's Health Specialists is a participating provider with the network affiliated with my insurance company. I am aware that if Statesboro Women's Health Specialists is an out-of-network facility, I may be responsible for greater out-of-pocket expense.

_____I understand that I am responsible for payment of my co-pays up front. I understand that I am also responsible for any deductibles/co-insurance on services rendered. (For surgical procedures, deductibles must be paid in full at time of preoperative appointment). I agree to make regular monthly payments on any balances due or risk my account being transferred to a collection agency. Account balances not paid within 4 months will be subject to added monthly interest fees. If my account is transferred to an outside collection agency. I am aware that there will be additional collection fees of 25%-33% of the total balance added to my amount due.

_____I understand that it is my responsibility to provide **ALL** of my insurance information at the time services are rendered. If claims are later denied due to being past the filing time limit or if charges are denied by a secondary plan for failure to provide primary insurance information timely, I will be responsible **In full** for the charges incurred.

_____I understand that there is a $10.00 fee associated with completion of disability forms and a fee up to $0.97 per page for copying medical records in their entirety. The fees must be paid before the copies are released.

_____***For Medicaid recipients only**.....I am aware that if my Medicaid plan (GHP Medicaid, Amerigroup, or Wellcare) denies payment due to a service being "noncovered," I will be responsible for payment in full of those services.

I understand that if my Medicaid plan pays for services rendered, then at a later date retroactively denies coverage, I will be responsible for payment in full of those services.

I understand that if I fail to notify the practice in a timely manner of additional insurance coverage considered primary to Medicaid, I will be responsible in full for any charges denied by Medicaid and/or denied by "other coverage" due to timeliness of claim submission.

Statesboro Women's Health Specialists Privacy Practices

Notice of Privacy Practices Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise To You, Our Patients

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the offices of Statesboro Women's Health Specialists, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April l4, 2003. and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Statesboro Women's Heath Specialists, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information. often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged to improve the health of the state and nation
- Source of data for our planning and marketing
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve
- Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who. what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Statesboro Women's Health Specialists, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request
- Inspect and obtain a copy of your health record as provided by 45 CFR l64.524 (reasonable copy fees apply in accordance with state law)
- Amend your health record as provided by 45 CFR l64.526
- Obtain an accounting of disclosures of your health information as provided by 45 CFR l64.528
- Request confidential communications of your health information as provided by 45 CFR l64.522 (b)
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR l64.522 (a) (however, we are not required by law to agree to a requested restriction)

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate your health information. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-handed corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment. Payment And Health Operations. without your written authorization, which you may revoke as provided by 45 CFR l64.508 (b) (5), except to the extent that action has already been taken.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer, Mary Collins, at 9l2-87l -2000.

If you believe your privacy rights have been violated, you can either file a complaint with Mary Collins, or with the Office for Civil Rights. US. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Georgia is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center. Suite 3870
6l Forsyth Street. SW.
Atlanta, GA 30303—8909

Examples of Disclosure for Treatment, Payment, and Health Operations

We will use your health information for treatment. We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best. Your medical information will be shared among health care professionals involved in your care.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment. We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:

If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.

We will use your health information for regular health operations.

We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement activities that are necessary to run our practice and support the core functions. *For example:*

Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare costs.

Appointment Reminders

We may disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

Decedents

Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

Worker's Compensation

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease. injury, or disability.

Research

We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review Board/Privacy Board, who reviewed the research proposal.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of donation and transplant.

As Required By Law

We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections, necessary to ensure compliance with government regulations and civil rights laws.

Specialized Government Functions

We may disclose health information for military and veterans affairs or national security and intelligence activities.

Business Associates

There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

Practice Marketing

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (e.g., to notify you of any new tests or services we may be offering).

Food and Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Personal Representative

We may disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).

To Avert A Serious Threat To Health/Safety

We may disclose information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

Communication With Family

Unless you object, health professionals may disclose to a family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.

Disaster Relief

Unless you object, we may disclose your health information to an organization assisting in a disaster relief. For all non-routine operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

Family History Questionnaire for Hereditary Breast and Ovarian Cancer

Patient Name: _____ Date of Birth: _____ Gender: M / F Ethnicity: _____

Please complete this questionnaire to assist your healthcare provider in determining if you are eligible for genetic testing or referral for further evaluation for hereditary breast and ovarian cancer (HBOC).

- Write the type of relative (e.g. aunt) who had each cancer in the corresponding box.
- Include the age at which the cancer was diagnosed whenever available.
- If you or a family member was diagnosed with a cancer more than once, include each diagnosis of cancer.
- Relatives on your mother's side of the family (maternal) should be listed in the pink boxes. Relatives on your father's side of the family (paternal) should be listed in the blue boxes.

The numbers in the boxes will be used by your healthcare provider to determine your eligibility for genetic testing or referral for further evaluation for HBOC.

Past genetic testing for cancer: ☐ Self ☐ Relative Result: _____

Patient Questionnaire: Hereditary Breast and Ovarian Cancer

Personal and Family History	You, siblings, children:	Maternal Relatives:		Paternal Relatives:	
	Column A You, siblings, nieces, nephews, children, grandchildren	**Column B** Mother, half-siblings, aunts, uncles, grandparents	**Column C** Great-grandparents, first cousins	**Column D** Father, half-siblings, aunts, uncles, grandparents	**Column E** Great-grandparents, first cousins
Example	*Sister Susie*		*Cousin Julie*	*Grandpa Tom*	
Ashkenazi Jewish ancestry and breast cancer	5	5	2	5	2
Ashkenazi Jewish ancestry and pancreatic cancer	5	5	2.5	5	2.5
BRCA1/BRCA2 pathogenic variant (also known as a mutation)	5	5	5	5	5
Ovarian cancer	5	5	3	5	3
Male breast cancer	5	5	3	5	3
Pancreatic cancer	2.5	2.5	2.5	2.5	2.5
Aggressive prostate cancer	2.5	2.5	2.5	2.5	2.5
Breast cancer:					
Two separate diagnoses (primaries) of breast cancer, at least one diagnosed <50y	5	5	3	5	3
Triple negative breast cancer*, age 60 or younger	5	5	3	5	3
Breast cancer, age 45 or younger	5	5	3	5	3
Breast cancer, age 46—50	3	3	3	3	3
Breast cancer, after age 50, or unknown age	2	2	2	2	2
Totals:	**A**	**B**	**C**	**D**	**E**

*Triple negative breast cancer refers to three receptors: (Estrogen Receptor (ER) negative, Progesterone Receptor (PR) negative, HER2 negative)

Healthcare Provider Use Only:	**Sum A, B, C:**	**Sum A, D, E:**	**Greater sum:**

Patient accepts genetic testing ( ) Patient declines genetic testing ( ) Patient will review information discussed before testing ( )

I verify the personal and family history above was reviewed with me: Patient signature: _____ Date: _____

Scoring Instructions:

- Sum each column separately. Then add the totals from columns A,B,C and A,D,E (for patient's maternal and paternal history, respectively).
- **A score of ≥5 from the total of columns A, B, C OR columns A, D, E indicate your patient is a candidate for genetic counseling and/or genetic testing for HBOC.**
- If a single cancer diagnosis is entered twice, choose a single box with the highest number.
- For multiple primary diagnoses, count each cancer separately. This includes bilateral breast cancer. Metastasis or recurrences of a single cancer should not be counted multiple times.
- If two relatives from the same column are entered in the same box, count the number twice.
- This assessment is based on National Comprehensive Cancer Network (NCCN) testing and referral criteria for hereditary breast and ovarian cancer, and is not a tool to determine cancer risk.
- The assessment can overestimate eligibility where there is family history in third-degree relatives only, or a family history of 2 breast cancers >50y and an additional pancreatic/prostate cancer. Please refer to the testing criteria below.

NCCN Genetic Testing Criteria for Hereditary Breast and Ovarian Cancer Syndrome

- Family history of a known BRCA1 or BRCA2 pathogenic variant (mutation)
- Personal history of breast cancer diagnosed at age 45 or younger
- Personal history of breast cancer diagnosed at age 50 or younger with one of the following:
  - ≥1 close blood relative(s) with breast cancer at any age
  - ≥1 close blood relative(s) with pancreatic or prostate cancer (Gleason score ≥7) at any age
  - An unknown or limited family history
  - Two breast primaries, one of which was diagnosed at age 50 or younger
- Personal history of a triple negative breast cancer diagnosed at age 60 or younger
- Personal history of epithelial ovarian, fallopian tube, or primary peritoneal cancer at any age
- Personal history of male breast cancer at any age
- Personal history of breast cancer at any age with one or more of the following:
  - ≥1 close blood relative(s) with breast cancer diagnosed at age 50 or younger
  - ≥2 close blood relatives with breast cancer at any age
  - ≥1 close blood relative(s) with epithelial ovarian/fallopian/tube/primary peritoneal cancer
  - Close male blood relative with breast cancer
  - ≥2 close blood relatives with pancreatic cancer and/or prostate cancer (Gleason score ≥7) at any age
  - For an individual of ethnicity associated with higher frequency of pathogenic variants associated with HBOC (e.g., Ashkenazi Jewish) no additional family history may be required
- Personal history of pancreatic cancer at any age with ≥1 close blood relative(s) with breast cancer diagnosed ≤ 50, and/or ovarian cancer at any age and/or pancreatic cancer at any age and/or prostate cancer (Gleason score ≥7) at any age
- Personal history of prostate cancer (Gleason score ≥7) at any age with ≥1 close blood relative(s) with breast cancer diagnosed ≤50, and/or ovarian cancer at any age and/or pancreatic cancer at any age and/or prostate cancer (Gleason score ≥7) at any age
- Personal history of pancreatic cancer and Ashkenazi Jewish ancestry

Patients without a personal history of HBOC-related cancers (breast, ovarian, pancreatic, prostate)

- Unaffected patient with a first– or second-degree relative who meets any of the above criteria
- Unaffected patient with a third-degree blood relative who has breast cancer and/or epithelial ovarian/fallopian/tube/primary peritoneal cancer and who has ≥2 close blood relative(s) with breast cancer (at least one ≤50) and/or epithelial ovarian/fallopian/tube/primary peritoneal cancer
- Testing unaffected individuals should only be considered when an appropriate affected family member is unavailable for testing

Close blood relatives include first-degree (parents, siblings, children), second-degree (grandparents, aunts, uncles, half-siblings, grandchildren, nieces, nephews) and third-degree (great-grandparents, great-aunts, great-uncles, first cousins).

Breast cancer includes invasive breast cancer, as well as ductal carcinoma in situ.

For patients of Ashkenazi Jewish ancestry, testing for Ashkenazi Jewish founder-specific pathogenic variant(s) in BRCA1/BRCA2 should be performed first. Further testing of BRCA1/BRCA2 and additional genes may be considered if ancestry also includes non-Ashkenazi Jewish relatives or other criteria are met.

NCCN Genetic/Familial High-Risk Assessment: Breast and Ovarian Guidelines Version 2.2015 are current as of June, 2015. Please visit *www.nccn.org* for the most current guidelines.

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New Patient Medical History (New or not seen in the last 12 months) Today's Date: ____/____/____

Name: _____Birthday: ____/____/____ Age: ___

Reason for Visit:_____

_____

Past Medical and Surgical History

Have you ever had the following: ***Primary/Local Physician:*_____

YES	ILLNESS	DATE OF ONSET		YES	ILLNESS	DATE OF ONSET
	Anemia				Gastric Reflux(GERD)/Ulcers	
	Arthritis				Heart Murmur/Mitral Valve Prolapse	
	Asthma				Heart Disease/Heart Attack	
	Anesthesia Reaction				High Blood Pressure	
	Blood Transfusion				High Cholesterol/Lipids	
	Bowel Problems				Kidney Disease/Stones	
	Blood Clots (legs/lungs)				Migraines/Headaches	
	Cancer Type:				Liver Disease	
	Depression/Anxiety				Lung Disease	
	Diabetes				Lupus	
	Diverticulosis				Rheumatic Fever	
	Drug/Alcohol Problem				Seizures/Epilepsy	
	Eating Disorder				Stroke	
	Endometriosis				Thyroid Disease	
	Gallbladder Disease/Stones				Tuberculosis	

List previous hospitalizations/surgeries/serious injuries: *When:*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all medications, supplements and vitamins that you take regularly: ***Pharmacy:*_____

Medication	Dosage	Times per day	Reasons for Taking

Allergies: List any allergies to medications, drugs, chemicals and/or foods: Date/Type of Reaction:

1. _____
2. _____
3. _____
4. _____

FAMILY MEDICAL HISTORY

Include blood relatives: Mother, Father, Sisters, Brothers, Aunts, Uncles, Grandparents (MGM, MGF, PGM, PGF)

**Age = The age when the family member was first diagnosed

ILLNESS	RELATIVE	AGE**		ILLNESS	RELATIVE	AGE**
Birth Defects				Mental Illness		
Blood Clots				Osteoporosis		
Breast Cancer				Ovarian Cancer		
Colon Cancer				Prostrate Cancer		
Depression				Stroke		
Diabetes				Thyroid Disease/ Cancer		
Heart Disease/MI				Uterine Cancer		
High Blood Pressure				Other:		

GYNECOLOGIC HISTORY (Circle Answer)

Have you ever had an abnormal pap smear: NO YES If yes, when:_____What Happened:_____

Infections: Any history of:(circle) Herpes Gonorrhea Chlamydia Genital Warts Trich HPV HIV Syphilis

Age at first period":_____ First Day of Last Menstrual Period: _____/____/____ How long did it last:_____

**If menopausal: What age did it occur:_____ Any bleeding since: YES NO Taking hormones: YES NO

**If having periods: Are they regular: YES NO How often do they occur:_____How long do they last:_____

Period flow: Light Medium Heavy Do you bleed between periods: YES NO Clots: YES NO

Current Method of birth control: (circle answer) Pills Patch IUD Nuva Ring DepoProvera Condoms Essure
Tubes Tied Vasectomy Foams/Sponge Implanon Rhythm Method

SOCIAL HISTORY (Circle Answer)

Marital Status: Single Married Separated Divorced Widowed

Alcohol Use: Never Occasionally Daily Former Age Started: _____Age Stopped: _____ Amount:_____

Tobacco Use: Never Occasionally Daily Former Age Started: _____Age Stopped: _____ Amount:_____

Illicit Drug Use: Never Occasionally Daily Former Age Started: _____Age Stopped: _____ Amount:_____

Education: Highest level or grade completed:_____Occupation:_____

History of Abuse: None Physical Sexual Emotional Details:_____

OBSTETRICAL HISTORY

Total Pregnancies #:_____ Full Term (Born after 37 wks) #:_____ Preterm (Between 20-37 wks) #:_____

Elective Abortions #:_____ Miscarriages (Prior to 20 wks) #:_____

Ectopic/Tubal Pregnancies #:_____ Multiple Pregnancies #:_____Living #:_____

**Only complete the section below if you are of child bearing age

Date	Pregnancy Week	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Complications	Location

GENETIC HISTORY

Do any of the following genetic problems run in your immediate family? NO YES (Circle and list relative)

Thalassemia	Neural Tube Defect	Heart Defect
Down Syndrome	Tay-Sachs Disease	Hemophilia
Canavans Disease	Sickle Cell Disease	Fragile X
Muscular Dystrophy	Cystic Fibrosis	
Huntington's Chorea	Mental Retardation/Autism	

Other:_____

CURRENT REVIEW OF SYSTEMS

Any symptoms that we need to discuss with you today? (circle all that apply)

CONSTITUTIONAL:	Fatigue	Fever	Weight Loss/Gain	Night Sweats
EYES:	Impaired Vision	Changes in vision		
ENT:	Headaches	Sinus Congestion	Decreased hearing	
BREASTS:	Lumps	Tenderness	Swelling	Nipple Discharge
CARDIOVASCULAR:	Chest Pain	Syncope/Feeling Faint	Swelling in feet	Palpitations
RESPIRATORY:	Shortness of Breath	Wheezing	Cough	
GASTROINTESTINAL:	Nausea	Vomiting	Diarrhea	Constipation Blood in Stool
GENITOURINARY:	Urgency/Frequency/Burning with Urination		Abnormal Vaginal Discharge	
	Abnormal Vaginal Bleeding		Abnormal Pain with Periods	
INTEGUMENTARY:	Rash	Changes to Existing Moles		New, Abnormal Moles
NEUROLOGICAL:	Muscle Wealness	Tingling/Numbness	Memory Problems	
MUSCULOSKELETAL:	Joint Pain	Muscle Pain	Muscle Weakness	
ENDOCRINE:	Excessive Urination	Excessive Thirst	Heat/Cold Intolerance	
PSYCHIATRIC:	Anxiety	Depression	PMS	
HEME/LYMPH:	Easy Bleeding	Easy Bruising	Swollen Lymph Nodes	
IMMUNITY:	Frequent Illness	Chronic Sinus/Allergy Problems		

STATESBORO WOMEN'S HEALTH SPECIALISTS

PO Box 1958, Statesboro, GA 30459 Phone: 912-871-2000 Fax: 912-871-2500

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal law, and outlining my rights regarding my health information.

Signed : _____Date:_____

Relationship to patient (if not signed by Patient):_____

I wish to place the following restrictions on disclosure of my health information:

_____

_____

_____

_____

Internal Use Only

If patient or representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on:_____: _____ Time: _____

By (name & title): _____