NEW PATIENT MEDICAL HISTORY FORM

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(required for access to your chart)

**MEDICATION LIST: (*include all prescription and non-prescription medications currently taking or have taken in last week)***

Include Name of Medicine, strength/dosage, and frequency or how often you take it (if more space is needed please bring list with you)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_\_\_\_NO \_\_\_\_\_\_\_\_ YES (**If yes, Please list below and indicate reaction that occurred)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF PHARMACY AND LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*All prescriptions will be sent electronically to your pharmacy unless indicated by your doctor at the time of your visit*.

**REASON FOR VISIT:** (please check one) \_\_\_\_\_Annual / Wellness Exam \_\_\_\_\_Gynecological visit / Problem \_\_\_\_\_Pregnancy Confirmation

**\_\_\_\_\_** Referral by Dr**.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROCEDURE HISTORY:**

Date of Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bone Density:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENSTRUAL HISTORY: (*Please fill in the blanks and circle yes or no where indicated)***

Age when Menstruation started: \_\_\_\_\_\_\_\_\_\_ Date of Last Menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did you have a period last month? YES / NO

Are your periods regular? YES / NO How often do you menstruate? Every \_\_\_\_\_\_\_days. How long do your periods last? \_\_\_\_\_\_\_\_\_\_\_\_days

Number of pads or tampons soaked in 24 hours on the heaviest day of bleeding? \_\_\_\_\_\_\_\_\_

Cramps are \_\_\_\_\_Mild \_\_\_\_\_Moderate \_\_\_\_\_Severe \_\_\_\_No pain

Do you have spotting between your periods? YES / NO Do you have bleeding or spotting after intercourse? YES / NO Do you douche? YES / NO

**CONTRACEPTION:** *(****Please check all that apply)***

\_\_\_\_\_\_ None \_\_\_\_\_ Attempting Pregnancy \_\_\_\_\_Birth Control Pills \_\_\_\_\_ IUD: (year inserted) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Natural Family Planning \_\_\_\_\_Condoms \_\_\_\_\_Contraceptive Ring \_\_\_\_\_ Contraceptive Implant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Menopause \_\_\_\_\_ Hysterectomy \_\_\_\_\_Tubal Ligation \_\_\_\_\_ Vasectomy

\_\_\_\_\_\_ Essure

Are you needing birth Control today? YES / NO Do you have a preference? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST GYNECOLOGIC HISTORY: *(Please check all that apply)***

Abnormal Uterine bleeding \_\_\_\_\_ Abnormal Pap Smear\_\_\_\_\_ Human Papilloma Virus (HPV)\_\_\_\_\_\_ Uterine Fibroids\_\_\_\_\_\_\_

Endometriosis\_\_\_\_\_ Vaginitis\_\_\_\_\_ Fibrocystic Breast\_\_\_\_\_ Breast Cancer: \_\_\_\_\_\_\_

Sexually Transmitted Disease: Gonorrhea\_\_\_ Chlamydia\_\_\_ Herpes\_\_\_\_ Syphilis\_\_\_\_ HIV\_\_\_\_ Trichomonas\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated\_\_\_\_\_ Divorced\_\_\_\_\_ Widowed\_\_\_\_\_

**Tobacco Use**: **Alcohol Use**: YES / NO **Drug Use**: YES / NO **Sexually activity**:

**\_\_\_** Never a smoker \_\_\_Daily # glasses\_\_\_\_\_ \_\_\_Current use: \_\_\_\_\_\_\_\_\_\_\_\_\_ History of sexual activity: YES / NO

**\_\_\_**Former smoker \_\_\_Weekly:\_\_\_\_\_\_\_\_\_\_ \_\_\_Currently in Rehab Currently sexually active: YES / NO

\_\_\_Current every day smoker \_\_\_Monthly:\_\_\_\_\_\_\_\_\_ \_\_\_Former use # of partners in last year\_\_\_\_\_

\_\_\_Current someday # of partners in lifetime \_\_\_\_\_

# Per day\_\_\_\_\_\_\_\_\_(pks/cig)

**PREGNANCY HISTORY:**

Total # Pregnancies \_\_\_\_\_\_\_Term Deliveries \_\_\_\_\_ Preterm Deliveries \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Ectopic \_\_\_\_\_ Living Children\_\_\_\_\_

***(Please complete the chart below concerning all pregnancies regardless of outcome. If you have had more than 5 pregnancies, list the remaining pregnancies on the back)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Delivery,**  **Termination or loss** | **# Weeks** | **Delivery Type**  *(Vag, C/S, VBAC,*  *Miscarriage, Abort***)** | **Spontaneous**  **Or Induction** | **Gender**  **M / F** | **Weight** | **Anesthesia**  None / Epid /Spinal | **PROBLEMS** *(Indicate reason for C/S*  *If Done)* |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Mark any previous problems related to pregnancies:

\_\_\_\_\_ Essential Hypertension \_\_\_\_\_Preeclampsia \_\_\_\_\_ Diabetes \_\_\_\_\_ Gestational Diabetes

\_\_\_\_\_ Preterm Labor \_\_\_\_\_ Preterm Delivery \_\_\_\_\_ Incompetent Cervix \_\_\_\_\_ Excessive vomiting

Other / Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genetic History: (Check all that apply and indicate which family member)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **X** | **Condition** | **Relationship** | **X** | **Condition** | **Relationship** | **X** | **Condition** | **Relationship** |
|  | Down Syndrome (Trisomy 21) |  |  | Sickle Cell Disease or Trait |  |  | Muscular Dystrophy |  |
|  | Neural Tube Defects |  |  | Thalassemia |  |  | Other Birth Defects |  |
|  | Congenital Heart Defects |  |  | Tay-Sachs |  |  | Other Genetic disorders |  |
|  | Hemophilia |  |  | Autism |  |  | Recurrent Pregnancy loss |  |
|  | Cystic Fibrosis |  |  | Mental Retardation |  |  |  |  |
|  | Huntington’s Chorea |  |  | Canavan Syndrome |  |  | NO KNOWN HISTORY |  |

**If you are currently pregnant, have you traveled outside the United States or been in contact with anyone having the Zika virus since your last menstrual cycle?** YES / NO

**FAMILY HISTORY: (Please indicate relationship of family member and whether paternal or maternal grandparent when applies)**

High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breast Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ovarian Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intestinal Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Clotting Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY: (Please indicate year or age when surgery occurred)**

Biopsy of Cervix\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abdominal Hysterectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gallbladder Removal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEEP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Laparoscopic Hysterectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appendectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cryo (freezing of Cervix)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaginal Hysterectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hysteroscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cone Biopsy of Cervix\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C-Section\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Laparoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dilation and Curettage (D&C)\_\_\_\_\_\_\_\_\_\_\_ Cerclage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Endometrial Ablation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Elective Abortion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Essure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ovaries Removed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tubal Ligation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breast Biopsy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mastectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO SURGERIES \_\_\_\_\_\_\_\_\_\_ (initials)

**MEDICAL HISTORY: (Please check all conditions you have been treated for both past and present)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **System** | **X** | **Condition** | **X** | **Condition** | **X** | **Condition** | **X** | **Condition** |  |  |
| **Cardiac:** |  | Heart Disease |  | Heart Failure |  | High Blood  Pressure |  | High Cholesterol |  | Other: |
| **Endocrine** |  | Diabetes |  | Hyperthyroid |  | Hypothyroid |  | Obesity |  | Other: |
| **Respiratory** |  | Allergy |  | Asthma |  | Emphysema |  |  |  | Other |
| **Gastrointestinal** |  | Acid Reflux |  | Irritable Bowel |  | Colon Cancer |  |  |  | Other: |
| **Urinary** |  | Urinary Tract  Infection |  | Kidney disorder |  | Kidney Stones |  |  |  | Other |
| **Muscular/**  **Skeletal** |  | Osteoarthritis |  | Low Back pain |  | Osteoporosis |  | Fibromyalgia |  | Other |
| **Neurological** |  | Headaches |  | Brain tumor |  | Seizures |  | Epilepsy |  | Other |
| **Psychiatric** |  | Anxiety |  | Depression |  | PMS |  | Bipolar Disorder |  | Other |

**Other conditions not indicated above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT COMPLAINTS: (Please check all that apply and give brief explanation)**

**REVIEW OF SYSTEMS: (Please circle all that apply and give brief explanation if needed)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Systemic** | None | Weight Change | Fever | Night sweats | Fatigue |
| **Sinus** | None | Sinus Pain | Congestion |  |  |
| **Head** | None | Headache | Eyes | Ears | Throat/Neck pain |
| **Breast** | None | Breast Pain | Nipple Discharge | Breast lump |  |
| **Chest** | None | Heart | Lungs | Cough |  |
| **GI** | None | Nausea | Vomiting | Abdominal Pain |  |
| **Genital Urinary** | None | Pain with urination | Loss of urinary control | Blood in urine | Genital lesion/sore |
| **Skin** | None | Skin rash | Mole | Sores |  |
| **Musculoskeletal** | None | Bone or joint pain | Muscle aches |  |  |
| **Endocrine** | None | Excessive sweating | Excessive thirst | Change in sex drive |  |
| **Psychological** | None | Sleep changes | Anxiety | Depression |  |
| **Neurological** | None | Dizziness | Seizures | Fainting |  |
| **Other** |  | | | | |

Other complaints not listed above or comments concerning complaints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any other doctors currently treating you. This information is needed for Continuity of Care: (Name and phone number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE REVIEW FORM AND INFORMATION FOR ACCURACY AND COMPLETE ALL AREAS SO WE MAY BETTER SERVE YOU.

**PAP SMEARS**

Your screening Pap smear could require a pathologist’s review. If a review is required, a cytology fee is automatically incurred and charged to the patient. This fee of $60 will not be covered under Wellness coverage, **but will** fall under non-routine medical benefits, and could be subject to deductible, co-pays, and coinsurance.

**HUMAN PAPILLOMA VIRUS TESTING (HPV)**

Human Papilloma Virus (HPV) is a common virus that affects both females and males. Most types are harmless, do not cause any symptoms, and resolve without treatment. Some are high risk and can cause cervical cancer or abnormal cells in the lining of the cervix that can sometimes turn into cancer.

If your pap smear shows atypical cells of undetermined significance (ASCUS), an HPV test for the High Risk subtypes may be ordered. If the results are negative, we will repeat your pap smear in one year. If the results are positive, we will call you into the office for additional testing.

HPV testing as a result of an abnormal pap smear will allow us to expedite testing and get results to you in a timely manner. There is an additional charge for HPV testing that is not covered under Wellness coverage, **but** will fall under non-routine medical benefits, and could be subject to deductible, co-pays, and coinsurance. The charge is approximately $100 for HPV testing and will be billed to your insurance.

By signing below, you acknowledge receipt of the information regarding possible cytology fees and HPV test fees and you acknowledge that you and/or your insurance may be charged if medically necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (PRINT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. YOU MAY ALSO FAX TO 601-936-1416 OR 601-936-3664.**

**For your convenience and compliance with medical legal requirements, East Lakeland OB-Gyn Associates provides our patients with On-line Patient Portal access. An invitation to the Portal will be sent to your email address that you provide us. Open the invitation and follow the link to complete the set up process. This will be your connection with your doctor and our staff to review test results, request prescription refills and ask questions concerning your care and health.**

**Thank you for choosing East Lakeland OB-Gyn Associates**