Women's Health Care Specialists

Obstetrical Questionnaire

Patient Name_____

GASTROINTESTINAL	YES	NO	NOTES
Weight Loss			
Weight Gain			
Fatigue			
REPRODUCTIVE			
Itching			
Vaginal Discharge			
Irregular Bleeding			
Heavy Periods			
Bleeding Between Periods			
Painful Periods			
Painful Intercourse			
Night sweats/hot flashes			
BREAST			
Pain in Breast			
Nipple Discharge			
Masses/lumps			
CARDIO/PULMONARY			
Irregular Heartbeat			
Chest Pain			
Wheezing			
Shortness of Breath			
Chronic Cough			
GASTROINTESTINAL			
Diarrhea			
Bloody or Black Stool			
Nausea/Vomiting			
Constipation			
Heartburn			
URINARY			
Blood in Urine			
Painful Urination			
Leakage of Urine			
Incomplete Emptying			
MUSCULOSKELETAL			
Joint Swelling			
Chronic Pain			
MENTAL HEALTH			
Depression			
Crying Frequently			
Insomnia			
Anxiety			
HEMATOLOGIC/LYMPHATIC			
History of Blood Clots			
Bruises frequently			
Enlarged Lymph Nodes			
SKIN			
Worrisome Moles			
Rash			
ALLERGIES			
PLEASE LIST ANY ALLERGIES			

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Consent for the Anti-HIV Blood Test

I have been informed that my blood will be tested in order to detect whether or not it contains antibodies to the human immunodeficiency virus (HN) which is the probable causation agent of acquired immune deficiency syndrome (AIDS). I understand the test is performed by drawing blood from my arm and processing the resulting specimen utilizing ELISA and Western Blot laboratory technology.

I have been informed that the ELISA test being utilized produces three (3) false positives (indicates presence of anti-HIV when it is not present) test results in every ten thousand (10,000) specimens processed, regardless of populations tested. I have also been informed that the test will be repeated, if positive, and a secondary level test (Western Blot) will also be performed. The combination of these tests reduces the possibility of a false positive to a very small fraction per ten thousand (10,000) tests processed.

I have been informed the ELISA test also fails to detect anti-HIV in rare instances and for a period of time immediately after infection with the virus. I have been offered re-testing if it is suspected that this has occurred.

I have been informed that if I have questions regarding the nature of the blood test, the expected benefits, the risks and alternative tests, I may ask questions before I decide to consent to the blood tests.

I have been informed that all positive HIV test results will be reported to the Health Department for partner notification. I have been informed that this reporting process does not require my consent and is mandated by law.

By my signature below, I acknowledge that I have been given all the information I have requested concerning this blood test. Therefore, I acknowledge that I have given consent for the performance of a blood test to detect antibodies to HN.

Patient Billing Consent: I further recognize that this testing will be filed for payment with my health insurance company.

Date:_____

Signature of Patient or Guardian _____

Printed Name _____