Ideal Women's Health Specialists

Srisawai Pattamakom, MD

Kenesha Colson, PA Sarah Rasmussen, NP,CNM

2945 Loma Vista Road, Ventura, CA 93003

Tel. (805) 667-8003, Fax. (805) 667-8404

Info@idealwomens.com www.idealwomens.com

Dear Patient,

Welcome to our practice. We know there is a lot of paperwork involved; however, this is to insure that we don't miss a thing about you. The following pages include general information, health history and release of medical records that you think is pertinent to your health history.

Please check with your insurance company in regards to your covered benefits and please bring your insurance card and another form of identification with you.

If you are a minor, please bring one of your parents or guardian. They are always welcomed in the exam room but you also have the right to be interviewed and seen privately and discussions are kept confidential.

Hope to see you soon!

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Date_____ Referred by _____

Name_____ DOB_____Age_____

Home Address_____ City_____State_____Zip_____

Mailing Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____Email_____

Preferred Method of Contact: ( )Patient Portal ( )Cell Phone ( ) Home Phone ( )Mail ( ) Other_____

Social Security _____Drivers License_____Exp_____

Employer_____Occupation_____

Spouse or Significant Other:_____Spouse SSN:_____

Parents or Emergency Contact name and number:_____

INSURANCE INFORMATION

( ) No Insurance

Primary Insurance	Secondary Insurance
Insurance Company_____	Insurance Company_____
Subscriber's name_____	Subscriber's name_____
ID#_____Group#_____	ID#_____Group#_____
Birthdate_____SSN_____	Birthdate_____SSN_____
Subscriber's relationship to patient_____	Subscriber's relationship to patient_____

AUTHORIZATION FOR TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize the examination and treatment of the patient named above. I hereby authorize the direct payment or payment that might have been issued to the patient to Ideal Women's Health Specialists of any insurance benefits otherwise payable to or on behalf of the patient for any medical and/or surgical expenses. I understand that I am financially responsible for these charges. I hereby authorize Ideal Women's Health Specialists to release to my insurance company any information acquired in the course of my care to allow them to process any claims for medical and/or surgical services.

_____ _____ _____

Responsible party signature Date Responsible Party Name (please print)

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PATIENT CONSENT, AUTHORIZATION and ACKNOWLEDGMENT

1. **Consent to Treatment.** I hereby authorize Ideal Women's Health Specialists, through its physicians and health care staff, to provide medical services to me, and I hereby consent to the performance of laboratory tests, diagnostic procedures, and other medical treatment as discussed with my physician.

2. **Financial Agreement.** I hereby agree, that I am individually obligated to pay all charges for services rendered to me in accordance with the regular rates and terms of Ideal Women's Health Specialists. I accept full financial responsibility for all charges billed and guarantee to pay all such charges. In the event my account must be placed with an attorney or collection agency to obtain payment, I further agree to pay actual attorneys' fees and collection expenses. All accounts are due and payable upon presentation of a statement. I understand that if any bill remains unpaid thirty (30) days after the bill is due, a late payment fee of one percent (1%) per month will be charged on the unpaid balance.

3. **Ancillary Services.** I understand that the services furnished by another provider (such as laboratory tests, diagnostic procedures, and other medical treatments) will be billed separately by the provider furnishing the service and I further understand that I am financially responsible for the bill from these providers. I further understand that Ideal Women's Health Specialists has no obligation to determine whether such other providers are covered by my health plan or health insurance benefits.

4. **Assignment of Benefits.** I hereby assign Ideal Women's Health Specialists and authorize payment directly to it of any and all health insurance or health plan benefits (including Medicare) otherwise payable on my behalf or to me for services rendered. I understand and agree that I am financially responsible for any charges not paid by health plan or insurance benefits or otherwise not covered by this assignment (including, but not limited to, copayments, coinsurance, and deductibles) and agree to pay the full cost of such charges for the service rendered.

5. **Health Care Plans.** I understand that Ideal Women's Health Specialists contracts with various health care plans. If services rendered are found to be non-covered by a contracted health care plan, or if I am not eligible to receive services by a contracted health care plan, I agree to be individually obligated to pay the full cost of the services rendered to me by Ideal Women's Health Specialists.

6. **Release of Information.** I understand that Ideal Women's Health Specialists may release and disclose all or portions of my payment record for treatment, payment or health care operations in accordance with federal and state law. I hereby authorize Ideal Women's Health Specialists to make such disclosures to any person or entity which is or may be responsible for all or part of the charges for services rendered to me (including, but not limited to, insurers, employers, health care plans, welfare funds and worker's compensation carriers) for the purpose of obtaining payment, and to other health care providers for diagnosis or treatment. I understand that special permission is needed to release HIV test results, treatment information regarding drug or alcohol abuse and certain mental health records.

7. **Privacy Notice Acknowledgement.** I hereby acknowledge that I have access to a copy of Ideal Women's Health Specialists, Notice of Privacy Practices.

I hereby certify that I have read, understand, and accept the above terms and conditions. I further certify that I am the patient or the patient's legal representative and am authorized to sign this document. I understand that I have a right to receive a copy of this document.

_____ _____

Patient Name Name of Patient Representative

_____ _____

Signature of Patient/ Patient Representative Relationship to Patient (attach copy of legal authority)

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Name:_____DOB_____ Age_____Date _____

Reason(s) for visit_____
ALLERGIES_____

Last normal menstrual period:_____ Age at first menstrual period _____
Length of periods _____ Number of days between periods_____
Heavy periods? □ yes, □ no Painful periods? □ yes □ no Bleeding between? □ yes □ no
Sexually active? □ yes, □ no Painful intercourse? □ yes □ no Vaginal Discharge? □ yes, □ no
Recent PAP test:_____Any abnormal results? □ yes □ no High Risk HPV? □ yes □ no
Recent Mammogram:_____Any abnormal results? □ yes □ no
Previous Colonoscopy?:_____Last bone density if applicable:_____
Contraception: □ pills □ Depo-Provera □ IUD, Mirena/Paragard □ condoms □ Nexplanon
□ Tubal ligation □ vasectomy □ natural family planning □ other _____
Do you leak urine? □ No □ all the time □ with lifting/coughing □ only occasionally
Do you wear incontinence pads often? □ yes □ no Do you have difficulty stopping or starting your stream? □ yes □ no

OB/GYN HISTORY
Total pregnancies_____Living_____Miscarriages_____Abortions_____Ectopic____ Csection_____
□ Condyloma/warts □ Endometriosis □ Fibroids □ Genital Herpes □ Gonorrhea/Chlamydia □ Severe Pelvic Infection
□ Infertility □ Frequent utis □ Ovarian Cysts

MEDICAL HISTORY □ none

□ Asthma	□ High blood pressure	□ Breast Cancer	□ Thyroid Problem	□ Depression	□Anxiety
□ Anemia	□ Heart Problem	□ Fibrocystic breasts	□ Lupus	□ Migraines	
□ Arthritis	□ Stroke/TIA	□ Osteoporosis	□ Glaucoma		
□ Diabetes	□ Deep vein thrombosis	□ Ulcerative colitis, IBS, Crohn's		□ Ulcer/GERD	
□ High cholesterol	□ Bleeding Problem	□ Liver Problem	□ Kidney Problem		

Others_____ _____

SURGICAL HISTORY □ none

□ Cone/LEEP	□ Hysterectomy(ovaries?)	□ Lumpectomy/Mastectomy	□ Appendectomy	□Gastric bypass
□ D&C	□ Bladder procedure	□ Breast biopsy	□ Back surgery	□ Tummy tuck
□ Cryotherapy	□ Ovary proc	□ Breast implants	□ Hip surgery	□ Thyroidectomy
□ Ablation	□ Myomectomy	□ C-section	□ Knee surgery	
□ Laparoscopy	□ Hysteroscopy			

Others_____

MEDICATIONS (name, dosage and frequency, including herbs)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

SOCIAL HISTORY

( ) Single ( )Significant other ( ) Married X _____yrs ( ) Divorced ( ) Widowed _____yrs?
Have you ever been sexually active? □ yes □ no
Are you currently sexually active? □ yes □ no with Men____ Women_____ Both_____

Do you smoke? □ yes □ no. If yes, packs per day?_____How many years?_____
Marijuana?_____If yes, how_____what for?_____
Drugs?_____
Are you interested in smoking cessation? □ yes! □ may be next year
How much alcohol do you drink?_____ Caffeine?_____
How much do you exercise(what do you do)?_____
Do you have pets? What kind?_____

FAMILY HISTORY

Mother (age, health status) _____ Father _____
Sisters_____ Brothers_____

□ breast cancer (mother, aunt, sister), □ ovarian ca, □ uterine ca, □ cervical ca, □ colon ca
□ diabetes, □ heart disease, □ high cholesterol, □ heart attack □ hypertension, □ osteoporosis

REVIEW OF SYSTEMS □ All good

Endocrine □ good □ weight loss □ weight gain (how many pounds/length of time_____)
□ fever/chills □ fatigue □ heat/cold intolerance□ rash □ bruises easily □ excessive thirst

Eyes/ears/nose/throat □ good □ sinusitis □ headache □ hearing loss □ sore throat
□ visual blurring □ ulcers □ cataracts □ glaucoma

Cardiovascular □ good □ chest pain □ swelling of legs □ palpitations

Respiratory □ good □ wheezing □ shortness of breath □ coughs

Breast □ good □ pain □ new lump □ discharge

Gastrointestinal □ good □ diarrhea □ bloody stool □ chronic constipation
□ nausea/vomiting/indigestion □ soiling of stool □ change in stool

Musculoskeletal □ good □ muscle weakness □ muscle or joint pain

Urinary □ good □ blood in urine □ painful urination □ frequent urination □ frequent infection
□ incomplete emptying □ leaking urine

Gynecologic □ good □ abnormal periods □pelvic pain… □ with period , □ with sex, □all the time
□ odorous vaginal discharge □ mood swings/depression □ decreased libido
□ hot flashes □ vaginal dryness □ constant bulge in vagina □ sleeping problem

Neurologic □ good □ dizziness □ seizures □ numbness/tingling

Psychiatric □ good □ depression □ severe anxiety □ bipolar □ history of abuse

Please fill out this section if being seen for pregnancy:

Name:_____DOB_____

Last menstrual period_____Are you regular?_____Were you on birth control?____

OBSTETRIC HISTORY

I: (total) Pregnancies_____Births_____Miscarriages_____Cesarean_____Abortions_____Living_____

Births: starting with oldest child:

Year born_____ Weight_____weeks of pregnancy_____Vaginal birth _____ C/S_____
Year born_____ Weight_____weeks of pregnancy_____Vaginal birth_____ C/S_____
Year born_____ Weight_____weeks of pregnancy_____Vaginal birth_____ C/S_____
Year born_____ Weight_____weeks of pregnancy_____Vaginal birth_____ C/S_____
Year born_____ Weight_____weeks of pregnancy_____Vaginal birth_____ C/S_____
Year born_____ Weight_____weeks of pregnancy_____Vaginal birth_____ C/S_____

Fertility Treatment?_____IVF?_____Surrogacy?_____
Any obstetric complications?_____

_____

II: Are you and/or your husband/significant other of Ashkenazi Jewish, Cajun, Asian or French Canadian descent?_____

Any Genetic and/or Congenital Issues in either family?_____

□ Cystic Fibrosis □ Hunting's chorea □ Taysachs. □ any Birth Defects?_____
□ Congenital Heart disease □ Sickle cell disease/trait_____
□ Hemophilia □ Mental retardation or Fragile X?_____

III: History of Infection:
Do you suspect you might have been exposed to Zika from your travels recently? □ Yes □ No
Any exposure to tuberculosis? □ Yes □ No
Any viral illness since last menstrual period? □ Yes □ No
Any exposure to medication/street drugs/alcohol since last menstrual period? □ Yes □ No

If yes, please list_____

IV: ***Do you want Genetic Screening to screen for Chromosomal anomalies?***

http://www.cdph.ca.gov/programs/GDSP/Documents/6x9%20Patient%20Booklet%20Consent%20July%202016.pdf

Knowing early that the baby has lethal genetic defects may give you the option of an earlier decision in regards to the course of the pregnancy. Everyone carries a certain amount of risk. At the age of 20, a woman carries a 1 in 1000 chance of having a baby with Down's syndrome or Trisomy 21. In her 30's, 1 in 350, in her 40's 1 in 60.

*****If you are or will be 35 at the time of birth,** you have the option of exploring testing for Downs's syndrome, or trisomy 21, the most common, Trisomy 13, 18, and Smith Lemli Opitz Syndrome as well as neural tube defect, ie spina bifida, etc.

Option A: The **California Prenatal Screening** which is offered in two stages. First trimester screening which includes blood work 10-13^{+6} wks and Nuchal Translucency (the measuring of nuchal fold thickness) can be performed between week 11^{+2}-14^{+2} weeks. This is followed by a **second test or QUAD screen** between weeks 15-20. Both of these tests are usually **covered by the state of California and most insurances**. These tests, coupled With detailed ultrasound after the 15th week are within 85-90 % accuracy.

Option B: Another available test is **the non-invasive prenatal test or NiPT also known as cell-free DNA**, which checks the chromosome of the circulating fetal cells in maternal blood. This has become more widely used because of its noninvasive nature and the high specificity of the result. This can also tell the gender of the fetus. This can be done as early as the 10th week. Accuracy is between 90-98%. More accurate if you're over 35.

Option C(Gold Standard) : CVS or Chorionic Villus Sampling can be done as early as the 9th week as well but is quite invasive and you will be referred to a tertiary center such as UCLA, Cedars or USC. **Amniocentesis** is a less invasive (still requires placing a needle in the uterus) but is not performed until the 15-16th week and may yield result later into the 18th week.

Options A and B are not the Gold Standards but good Screening Tests. If any of the above options returned as abnormal, then you will be recommended for Amniocentesis and consultation with a Genetic Counselor and a Perinatologist.

V: **Prenatal Visits**: until week 28, every month. Thereafer, every 2 weeks, then every week a month prior to due date.
First Visit: CBC –bloodcount, Type and Screen – check your blood type, if Rh negative, you will receive Rhogam Immunity to Rubella, Chicken Pox. Sickle cell panel if unknown for African-American.
Infections from: Hepatitis B and C, Syphillis, Gonorrhea, and Chlamydiae, HIV if you have cats, also Toxoplasmosis
Nuchal Translucency 11-14 weeks. NIPT can be done as early as 10 weeeks.
Between 15-20 weeks, QUAD screen to assess risks for Trisomy 21 (most common), 13, 18 and risk of one Type of fatty acid metabolism disorder, and neural tube defect i.e. spina bifida.
Anatomy Scan of baby around 17-19 weeks.
Between 24-28 weeks: Gestational Diabetes screening or one hour glucola. Discussion of Tdap (whooping cough) vaccine after 27th week. Another Growth Scan is common around this time.
If RH negative, Rhogam work up will be done during this time.

If you're pregnancy is a bit extraordinary i.e. high blood pressure, diabetes, any other nonstandard issues, you Will be referred to see a Perinatologist who will help us optimally manage your pregnancy.

VI: General Guidelines: Good info: What to Expect When You're Expecting or A Girlfriend's Guide To Pregnancy. Of course, there are many Aps you can play with. http://mothertobaby.org/.
Protein consumption should be around 50 grams/day. Avoid unpasteurized cheese. Sushi? Ok. Please avoid raw oysters or unpasteurized cheese.
Calcium 2000mg/day. **Omega-3** now comes with PNV but can be taken separately. Can be in the form of supplements or dairy products.
Generally, don't have to consume more than 300 cals/day extra.
Can continue to exercise unless spotting/cramping a lot, then hold off until cleared by MD.
Intercourse generally safe throughout unless spotting/cramping a lot, then hold off until cleared by MD.

VII: **Disability**: Generally, can continue to work until delivery. However, state disability can be requested according to the your health situation. **Disabilty for uncomplicated pregnancy starts at 36 weeks and ends 6 weeks after a vaginal** delivery, or **8 weeks after cesarean section**. This can be extended (without pay) using Family Leave, for an additional 6 weeks. Also, if workplace offers additional days, then you may extend further. It's easier/faster to fill out disability form online: http://www.edd.ca.gov/Disability/SDI_Online.htm but we do have the paper version. The process takes 2 weeks.
VIII: **Travel** – up until 35 weeks.
IX: When you get sick
Cold/Flu- treat symptoms. Hydrate. Hydrate. Hydrate. Tylenol is SAFE. Take for temperature greater than 100.4.
Diarrhea- Imodium ok. Call if not improved after 48 hours. Hydrate. Hydrate. Hydrate. Tylenol ok For cramps.**Headaches –** we generally recommend Tylenol but if that doesn't work, a tablet of ibuprofen occasionally is ok.