## *Atlanta Minimally Invasive Gynecologic Surgery Center*

Gyn Appointment Form

***Please have patient fill in the following information:***

Today's Date: ____/____/____ Circle one: Established patient Referral Self-referral

Referring Provider's Name/Contact #: ____________________

Primary Care Provider's Name/Contact#: ____________________

Name: ____________________ Age: ________ DOB: ________

Best daytime contact number: ____________________

What brings you to see us today? ____________________

Age menstruation began? ________ How often do you get periods? ________ How long do they last? ________

Have you ever had an abnormal papsmear? ________ If so, when? ________

Have you had any previous treatments on your cervix (LEEP, freezing, colposcopy, biopsies)?

____________________

Have you had any other gynecologic surgery (tubal ligation/hysterectomy/ovaries removed)?

____________________

Have you ever had an STD (gonorrhea/chlamydia/syphilis/herpes/trich/HIV/HPV)?

____________________

Has anyone in your family had breast, colon, ovarian, uterine, cervical, vaginal, or vulvar cancer?

____________________

Current medications/vitamins: ____________________

Any drug allergies? ____________________

Are you interested in STD testing? ________ Please circle: Gonorrhea/Chlamydia/HIV/Syphilis/Hepatitis/Herpes

Do you currently use tobacco/smoke or have you in the past? ____________________

Are you taking medication or Calcium/Vitamin D for prevention or treatment of osteoporosis? ________

Do you exercise regularly? If so, list activities: ____________________

**Are you currently experiencing any of the following: circle answer**

Heavy bleeding during your periods? Yes / No / NA

Bleeding in between your periods? Yes / No / NA

Postmenopausal bleeding? Yes / No / NA

Bleeding after intercourse? Yes / No

Significantly painful periods? Yes / No / NA

Significantly painful intercourse? Yes / No

Chronic pelvic pain? Yes / No

Significant hot flashes? Yes / No

Significant vaginal dryness? Yes / No

Abnormal vaginal discharge? Yes / No

Loss of urine when cough or sneeze? Yes / No

Loss of urine when you feel urgency? Yes / No

Frequent abdominal bloating? Yes / No

Have bowel movements at least 3 x week? Yes/No

Blood in urine or stools? Yes / No

Chronic diarrhea? Yes / No

Recent significant weight changes? Yes / No

Fever/chills/nausea/vomiting? Yes / No

***For Office Staff:***

Gravida ______ Para ____/____/____/____ # NSVD ________ # C/S ________

First day of LMP: ____/____/____ Method of birth control, if applicable? ____________________

Date and result of last papsmear: ____/____/____ ☐ within normal limits ☐ abnormal

HPV testing done? ________ ☐ positive ☐ negative Date and result STD testing: ________

Last Mammo ________ Last PE ________ Last DEXA ________ Last colonoscopy ________

Vitals: BP: ____/____ Ht: ______ Wt: ______ BMI: ______ T: ______ P: ______ R: ______

Hemoglobin: ________ UA: ☐ wnl ☐ leuk ☐ nitr ☐ prot ☐ gluc ☐ blood

Urine pregnancy test: ☐ positive ☐ negative

***MD/NP Notes*:**

**Subjective:** ____________________

____________________

**PMH:** ____________________

**PSH:** ____________________

**Social:** ____________________

**FH:** ____________________

<u>Atlanta Minimally Invasive Gynecologic Surgical Center, LLC</u>
A.M.I.G.S, LLC

<u>Routine Procedures</u>

REQUEST AND INFORMED CONSENT

**Important: Do not sign this form without reading and understanding its contents.**

**Patient's Name: ____________________________ Date of Birth: ______________**

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals").

While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every procedure and this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures

The Procedures may include, but are not limited to the following:

1. **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
2. **Physical test, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and similar procedures. The material risks associated with these types of procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.
3. **Administration of Medications** whether orally, rectally, topically or through your eye, ear or nose. The material risks associated with these types of Procedures include but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
4. **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding or loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
5. **Insertion of Internal Tubes** such as bladder catheterizations, nasal gastric tubes, rectal tubes, drainage tubes, enemas etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

I understand that:

- The physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure or treatment, which has been explained.

- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure.
- During the course of the procedure or treatment described above it may be necessary or appropriate to perform additional procedures or treatments that are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures and treatments. I also consent to and authorize the performance of such additional procedures and treatments, as they deem necessary.
- Results or outcomes of my procedure(s) may be presented in scientific meetings or published research or used for teaching purposes, but that the physicians and medical staff will safe guard my personal privacy.
- I also consent that any tissue, specimens, organs or limbs removed from the patient's body in the course of any procedure or treatment may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

By signing this form:

- I acknowledge that I have read or had this form read and/or explained to me
- That I fully understand its contents
- That I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form.

I hereby voluntarily request and consent to the performance of the procedures or treatments described or referred to herein by Dr. _______________ and any other physicians or medical personnel who may be involved in the course of my treatment.

| ______________________________ | ______________________ | ________________ |
|---|---|---|
| Signature of Patient<br>(Or person giving consent) | Relationship | Date |

| ______________________________ | __________________________________ |
|---|---|
| Patient unable to sign because | Witness |

Additional materials used, if any, during the informed consent process for this procedure included:

______________________________________________________________________

Person disclosing information for consent: ____________________________________

06/07 revised