

## ***Ideal Women's Health Specialists***

**Srisawai Pattamakom, MD**

**Kenesha Colson, PAC Sarah Rasmussen, NP, CNM Sarah Dinkler, NP, CNM**

2945 Loma Vista Road, Ventura, CA 93003

Phone (805) 667-8003, Fax (805) 667-8404

[Info@idealwomens.com](mailto:Info@idealwomens.com) [www.idealwomens.com](http://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 visit our website for more information, pay your bills and request appointments as well.

Please check with your insurance company in regards to your covered benefits and please bring your insurance card and 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!

Srisawai Pattamakom, MD

Kenesha Colson, PAC

Sarah Rasmusen, NP, CNM

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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**

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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

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

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**If being seen for a Pregnancy, please fill out this section**

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     Tay Sachs.     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<sup>+6</sup> wks and Nuchal Translucency (the measuring of nuchal fold thickness) can be performed between week 11<sup>+2</sup>-14<sup>+2</sup> 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 15<sup>th</sup> 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 10<sup>th</sup> 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 9<sup>th</sup> 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 15-16<sup>th</sup> week and may yield result later into the 18<sup>th</sup> 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. Thereafter, 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, Syphilis, Gonorrhea, and Chlamydiae, HIV if you have cats, also Toxoplasmosis Nuchal Translucency 11-14 weeks. NIPT can be done as early as 10 weeks.

**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 27<sup>th</sup> 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. **Disability 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](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.