Conejo Women's Medical Center
415 Rolling Oaks Drive, Suite 260
Thousand Oaks, CA 91361

Karie McMurray, M.D.

Today's Date: _____

Name: _____ Date of birth:_____ Age:_____

Height: _____ Weight: _____

OB-GYN HISTORY

Number of Pregnancies _____
Number of Full Term Deliveries _____
Number of Premature Deliveries _____
Number of Miscarriages _____
Number of Abortions _____
Number of Living Children _____
Number of Ectopics _____

Date	Type of Delivery	M/F	Complications	Days in Hosp.
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Age onset of periods _____
Regularity every _____ days
Length of period _____ days
Clots? Yes or No
Cramps? Yes or No
Date of first day of last period _____
Was it a normal period? Yes or No
Date of last PAP smear_____
Normal? Yes or No
Have you ever had an abnormal PAP Smear?
Yes or No
Date of last mammogram?_____
Normal? Yes or No
Date of last bone density: _____
Date of last colonoscopy: _____

SURGICAL & MEDICAL HISTORY

Have you ever had (If yes, please explain)
Surgical Operations: _____
_____
_____
_____

Serious or Chronic Medical Illnesses: _____
_____
_____
_____

SEXUAL HISTORY

The following personal questions aid in your care. If you feel uncomfortable answering these questions please discuss your concerns with your doctor.

Yes	No		
☐	☐	Gonorrhea	Are you or have you been sexually active: Yes or No
☐	☐	Syphilis	Age of first intercourse: _____
☐	☐	Infection to your tubes	Do you or your partner notice any looseness of vaginal tissue during
☐	☐	Vaginal Infection	sex? Yes or No
☐	☐	Genital Herpes	Do you ever lose urine with coughing, sneezing, or sex? Yes or No
☐	☐	Chlamydia	Discharge/Bleeding after intercourse? Yes or No
☐	☐	Genital Warts	Are there any aspects of your sexual lifestyle that may affect your
			care? (Bisexual partners, more that 1 partner in the last 3 months)
			Yes or No

Check any of the following medical conditions which you (or your family) have had:

Patient	Family		Patient	Family	
☐	☐	Tumor or Masses of the Breasts	☐	☐	Varicose Veins
☐	☐	Diabetes	☐	☐	Phlebitis (Blood clots in veins)
☐	☐	Epilepsy or Convulsions	☐	☐	Pulmonary Embolus(Clots in lung)
☐	☐	High Blood Pressure	☐	☐	Asthma
☐	☐	Blurred or Abnormal Vision	☐	☐	Thyroid Disease
☐	☐	Rheumatic Fever	☐	☐	Fibroids (Tumors of Uterus)
☐	☐	Fluid Retention	☐	☐	Cancer: Specify_____
☐	☐	Depression	☐	☐	Heart Attack or stroke
☐	☐	Gastrointestinal Disease	☐	☐	Gallbladder Disease
☐	☐	Kidney Disease or Bladder Infection	☐	☐	Other: Specify_____
☐	☐	Hepatitis (Liver Disease)	☐	☐	Exposure to DES

Do you smoke:	Yes	No	Have you had a blood transfusion:	Yes	No
Do you drink alcohol:	Yes	No	Intravenous drugs:	Yes	No
Social drugs:	Yes	No	Do you exercise:	Yes	No

ALLERGIES - MEDICATIONS

Check any of the following in which you are allergic

☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Contraceptive Cream ☐ Sulfa ☐ Aspirin

☐ Other medications: (Give names) _____

BIRTH CONTROL METHODS

What form of Birth Control are you presently using?

☐ Pill ☐ IUD ☐ Diaphragm ☐ Condom ☐ Foam or Cream ☐ Withdrawal ☐ Rhythm ☐ Vasectomy ☐ None

Do you plan to continue present form of Birth Control? Yes or No

The new method you wish to use is:_____

Is there any other information pertinent to your health care:_____

Patient Medication List

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Are you allergic to any medications? □ Yes □ No

If so, please list the medications and reactions: _____

_____

Please list all medications you are taking (Prescriptions, Over the counter, Vitamins, and Supplements):

Name:	Dose:	How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any type of blood thinners? □ Yes □ No Do you take Aspirin? □ Yes □ No

Pharmacy:

Local Pharmacy (please list cross streets if known): _____

Mail Order Pharmacy: _____

Laboratory:

If lab work is sent, does your insurance require you to go to a specific lab? □ Yes □ No

If so, please specify: _____

CONEJO WOMEN'S MEDICAL CENTER

415 Rolling Oaks Dr. Suite #260
Thousand Oaks, CA 91361
(805) 371-4700

PATIENT INFORMATION

PLEASE PRINT

PATIENT	Mr. Mrs. Miss/Mrs. Last	First	MI	Home Phone:
Patient's Home Address		City	State	Zip
Patient Email Address		Cell Phone:		
Social Security #:	Date of Birth	Age	Sex	Driver's License #:
Patient's Employer	Work Address			Work Phone:
Spouse's Name	Spouse's Employer (Name & Address)			Work Phone:
Emergency Contact: (Local/Relative/Friend)	Name	Address		Phone:

REFERRED TO THIS OFFICE BY: _____

WHO IS YOUR PRIMARY PHYSICIAN? _____

INSURANCE	PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES WHICH COVER THIS PATIENT:		
PRIMARY:	Name	Policy #	Subscriber
	Insurance Address		Subscriber D.O.B.
SECONDARY:	Name	Policy #	Subscriber
	Insurance Address		Subscriber D.O.B.

RESPONSIBLE PARTY	Mr. Mrs. Miss/Mrs. Last	First	D.O.B.
Address			Phone
Occupation	Employers Name & Address		Bus. Phone:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____

PLEASE READ & SIGN THE FOLLOWING:
I directly assign all medical / surgical benefits to ***CONEJO WOMEN'S MEDICAL CENTER,*** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____

REVISED: 11/26/2014

Karie McMurray, M.D., F.A.C.O.G.
415 Rolling Oaks Drive, Suite 260 • Thousand Oaks, CA 91361
PHONE (805) 371-4700 | FAX (805) 371-4713

Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- How this office will use and disclose your protected health information
- Your privacy rights with regard to your protected health information
- This office's obligations concerning the use and disclosure of your protected health information

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ _____

Patient or Patient Representative Signature Date

_____

Patient or Patient Representative Printed Name

Doctors McMurray, Himsl, Santangelo, and Nikkhou
HIPAA Form

Name: _____ Date of Birth: _____

Provider (Please circle one):

Dr. McMurray Dr. Himsl Dr. Santangelo Dr. Nikkhou

Release of Medical Information

My Preferable method of contact is **(PLEASE CHECK ONE)**:

- □ Home Phone: _____
  - □ You may leave a detailed message
- □ Cell Phone: _____
  - □ You may leave a detailed message
- □ Email (Patient Portal): _____
- □ Postal Mail: _____

You may discuss my medical information with (please write full names not just relationships)

_____

_____

_____ _____

Signature of Patient Date