Mills
Obstetrics & Gynecology

NEW OBSTETRIC PATIENT FORM

PATIENT HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED PHONE #: _____ ALT. PHONE #: _____

EMAIL: _____

EMPLOYER: _____

MARITAL STATUS: SINGLE MARRIED LONG-TERM RELATIONSHIP DIVROCED WIDOWED

CURRENT INSURANCE: _____

ID#: _____ GROUP#: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

HOW DID YOU HEAR ABOUT US? _____

REASON FOR VISIT:

_____

_____

REFERRING PHYSICIAN: _____

PHARMACY NAME & ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

CURRENT MEDICATIONS (PLEASE LIST ALL MEDICATIONS, VITAMINS, AND SUPPLEMENTS)

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

IF YES, LIST MEDICATION AND REACTION:

VACCINE HISTORY

TDAP NO YES IF YES, DATE OF VACCINATION _____

PNEUMONIA NO YES IF YES, DATE OF VACCINATION _____

GARDASIL NO YES IF YES, DATE OF VACCINATION _____

SHINGLES NO YES IF YES, DATE OF VACCINATION _____

FLU NO YES IF YES, DATE OF VACCINATION _____

GYNECOLOGICAL HISTORY

AGE OF FIRST PERIOD: _____ DO YOU HAVE CRAMPS? NO YES

IS YOUR PERIOD FLOW: LIGHT MODERATE HEAVY

HOW LONG DO YOUR PERIODS LAST? _____

IF YOUR MENSTRUAL PERIODS ARE REGULAR; PERIODS START EVERY _____ DAYS

IF YOUR MENSTRUAL PERIODS ARE IRREGULAR, PERIODS START EVERY _____ TO _____ DAYS (e.g. 12 to 60)

FIRST DAY OF LAST MENSTRUAL PERIOD: _____ DATE OF PREGNANCY TEST: _____

WERE YOU ON BIRTH CONTROL WHEN YOU BECAME PREGNANT? _____ PREGNANCY PLANNED? NO YES

SEXUALLY ACTIVE? NO YES

CURRENT BIRTH CONTROL METHOD: _____

PAP SMEAR/ MAMMOGRAM

DATE OF LAST PAP: _____ HAVE YOU HAD TREATMENT FOR ABNORMAL PAP SMEARS? NO YES

HAVE YOU HAD...

CRYOTHERAPY NO YES IF YES, WHEN? _____ LASER NO YES IF YES, WHEN? _____

CONE BIOPSY NO YES IF YES, WHEN? _____ LOOP EXCISION NO YES IF YES, WHEN? _____

HAVE YOU HAD A MAMMOGRAM? NO YES IF YES, DATE: _____ RESULT: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

PREGNANCY HISTORY HAVE NEVER BEEN PREGNANT _____

OF PREGNANCIES _____ # OF FULL-TERM BIRTHS _____ # OF PRE-TERM BIRTHS _____

OF PREGNANCY LOSSES _____ # OF LIVING CHILDREN _____ # OF INDUCED ABORTIONS _____

DATE	PLACE OF DELIVERY	DURATION OF PREGNANCY	HOURS OF LABOR	TYPE OF DELIVERY	COMPLICATIONS WITH MOTHER/ INFANT	CHILD'S SEX	BIRTH WEIGHT	PRESENT HEALTH

FAMILY HISTORY

ILLNESS	RELATION	ILLNESS	RELATION
AIDS (HIV)	_____	HIGH CHOLESTEROL	_____
ANEMIA/ BLOOD DISORDER	_____	KIDNEY DISEASE	_____
ANESTHESIA COMPLICATIONS	_____	LUNG CANCER	_____
BIRTH DEFECTS	_____	OSTEOPOROSIS	_____
BREAST CANCER	_____	OVARIAN CANCER	_____
COLON CANCER	_____	RHEUMATOID ARTHRITIS	_____
DIABETES	_____	LUPUS	_____
ENDOMETRIAL CANCER	_____	STROKE	_____
HEART DISEASE	_____	UTERINE CANCER	_____
HIGH BLOOD PRESSURE	_____	OTHER	_____

PATIENT NAME: _____ DATE OF BIRTH: _____

SOCIAL HISTORY

DO YOU SMOKE? NO YES _____ PACKS/DAY FORMER SMOKER? NO YES _____ PACKS/DAY _____ YEARS

DO YOU VAPE? NO YES HOW OFTEN? _____

ARE YOU EXPOSED TO SECOND HAND SMOKE? NO YES

ARE THERE CO2/ SMOKE DETECTORS IN YOUR HOME? NO YES

DO YOU WEAR SEATBELTS ROUTINEY? NO YES

DO YOU ROUTINELY USE SUNSCREEN? NO YES

IS ANESTHESIA CONSULT PLANNED? NO YES

IS A BLOOD TRANSFUSION ACCEPTABLE IN AN EMERGENCY? NO YES

DO YOU HAVE AN ADVANCED DIRECTIVE? NO YES

DO YOU HAVE A BIRTH PLAN? NO YES

DO YOU LIVE WITH CATS OR HAVE EXPOSURE TO CAT LITTER? NO YES

HAVE THERE BEEN ANY CHANGES IN YOUR FAMILY OR SOCIAL SITUATION? NO YES

DO YOU FLY FREQUENTLY? NO YES

DO YOU HAVE ANY OCCUPATIONAL HEALTH RISKS? NO YES

HAVE YOU RECENTLY (WITHIN THE LAST 12 WEEKS OR DURING A CURRENT PREGNANCY) TRAVEL TO OR LIVE IN A ZIKA-AFFECTED AREA? NO YES

DO YOU HAVE ANY SYMPTOMS ASSOCIATED WITH THE ZIKA VIRUS (RASH, FEVER, JOINT PAIN, OR CONJUNCTIVITIS)? NO YES

EDUCATION LEVEL _____

STRESS LEVEL: LOW MEDIUM HIGH

DIET: REGULAR VEGETARIAN OTHER: _____

EXERCISE: TYPE_____ HOW OFTEN? _____

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL

HAS THERE BEEN A NEW SEXUAL PARTNER IN THE LAST YEAR? NO YES

IS SEXUAL INTERCOURSE PAINFUL? NO YES

DO YOU DRINK ALCOHOL? NO YES IF YES, HOW MANY DRINKS PER WEEK? _____

HAVE YOU HAD AN Y ALCOHOL SINCE YOU HAD A POSITIVE PREGNANCY TEST? NO YES

CAFFEINE INTAKE: NONE OCCASIONAL MODERATE HEAVY

DO YOU USE ILLICIT DRUGS? NO YES IF YES, WHAT TYPE? _____ LAST USED? _____

NUMBER OF HOURS OF SLEEP EACH NIGHT: _____

PATIENT NAME:_____ DATE OF BIRTH:_____

PAST OBSTETRICAL/ GYNECOLOGICAL SURGERIES

CHECK ANY THAT APPLY OR: _____ NONE

SURGERY	YEAR	SURGERY	YEAR
D&C	_____	LEFT OVARIAN CYST REMOVED	_____
HYSTEROSCOPY	_____	RIGHT OVARIAN CYST REMOVED	_____
INFERTILITY SURGERY	_____	LEFT OVARY REMOVED	_____
LAPAROSCOPY	_____	RIGHT OVARY REMOVED	_____
CESAREAN SECTION	_____	MYOMECTOMY	_____
		VAGINAL OR BLADDER REPAIR	_____

OTHER _____

PAST SURGICAL HISTORY (NOT OB/GYN) _____ NONE

SURGERIES/ HOSPITALIZATIONS	YEAR
_____	_____
_____	_____
_____	_____
_____	_____

OTHER SYMPTOMS _____ NONE

HAVE YOU HAD ANY OF THE FOLLOWING RECENTLY?

BREAST TENDERNESS	CRAMPING	FATIGUE	NAUSEA
VAGINAL BLEEDING	VOMITING	WEIGHT GAIN	WEIGHT LOSS

OTHER _____

PERSONAL MEDICAL HISTORY _____ NONE

AIDS (HIV) HERPES (HSV) ANEMIA/ BLOOD DISORDER HIGH BLOOD PRESSURE

ANESTHESIA COMPLICATIONS HIGH CHOLESTEROL ANXIETY DISORDER INFERTILITY

ARTHRITIS LUPUS KIDNEY OR BLADDER PROBLEMS ASTHMA LIVER DISEASE

BIRTH DEFECTS OR INHERITED DISEASE LUNG DISEASE: TYPE _____

BLOOD TRANSFUSION OVARIAN CANCER BREAST CANCER PSYCHIATRIC ILLNESS: TYPE _____

BREAST PROBLEM: TYPE _____ RHEIMATIC FEVER CANCER: TYPE _____

SEASONAL ALLERGIES CHLAMYDIA/GONORRHEA SEXUAL ABUSE/ DOMESTIC VIOLENCE DEPRESSION

STOMACH, BOWEL, OR GALL BLADDER PROBLEMS DIABETES: TYPE _____ SYPHILIS

ENDOMETRIOSIS THYROID PROBLEMS FEMALE/SEXUAL PROBLEMS TUBERCULOSIS

HEADACHES/ MIGRAINES VARICOSITIES (VARICOSE VEINS) HEART CONDITIONS

HEPATITS: TYPE _____ OTHER: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

ARE YOU OR WILL YOU BE 35 YEARS OF AGE OR OLDER AT DELIVERY? NO YES

THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND) MCV<80 NO YES

HAVE YOU OR THE BABY'S FATHER OR ANYONE IN YOUR FAMILIES EVER HAD THE FOLLOWING?

DOWN SYNDROME NO YES IF YES, WHO? _____ MUSCULAR DYSTROPHY NO YES IF YES, WHO? _____

CANAVAN DISEASE NO YES IF YES, WHO? _____ CYSTIC FIBROSIS NO YES IF YES, WHO? _____

NEURAL TUBE DEFECT (SPINA BIFIDA, ANENCEPHALY) NO YES IF YES, WHO? _____

CONGENITAL HEART DEFECT NO YES IF YES, WHO? _____

TAY-SACHS (JEWISH, CAJUN, FRENCH-CANADIAN) NO YES IF YES, WHO? _____

SICKLE CELL DISEASE OR TRAIT NO YES IF YES, WHO? _____ HUNTINGTONS CHOREA NO YES WHO? _____

HEMOPHILIA OR OTHER BLOOD DISORDER NO YES IF YES, WHO? _____

MENTAL RETARDATION/AUTISM NO YES IF YES, WHO? _____ WAS PERSON TESTED FOR FRAGILE X? _____

OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER NO YES IF YES, WHO? _____

MATERNAL METABOLIC DISORDER NO YES RECURRENT PREGNANCY LOSS OR A STILLBIRTH NO YES

PT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE NO YES _____

MEDICATIONS (INCLUDE SUPPLEMENTS, VITAMINS, HERBS), ILLICIT DRUGS/ALCOHOL NO YES

IF YES, AGENTS, STRENGTH, AND DOSE _____

ANY OTHER GENETIC HISTORY NO YES _____

LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB? NO YES

PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES? NO YES

RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD? NO YES

HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, OR SYPHILIS? NO YES

OTHER INFECTION HISTORY? NO YES

FATHER OF BABY'S NAME _____ PHONE # _____

IS HE INVOLVED? NO YES

PLEASE SELECT THE ANSWER THAT BEST DESCRIBES HOW YOU HAVE FELT IN THE LAST 7 DAYS:

I HAVE BEEN ABLE TO LAUGH AND SEE THE FUNNY SIDE OF THINGS

A. AS MUCH AS I ALWAYS COULD
B. NOT QUITE SO MUCH NOW
C. DEFINITELY NOT SO MUCH NOW
D. NOT AT ALL

I HAVE LOOKED FORWARD WITH ENJOYMENT TO THINGS

A. AS MUCH AS I ALWAYS COULD
B. NOT QUITE SO MUCH NOW
C. DEFINITELY NOT SO MUCH NOW
D. NOT AT ALL

PATIENT NAME: _____ DATE OF BIRTH: _____

I HAVE BLAMED MYSELF UNNECESSARILY WHEN THINGS WENT WRONG

A. NO, NEVER
B. NOT VERY OFTEN
C. YES, SOME OF THE TIME
D. YES, MOST OF THE TIME

I HAVE BEEN ANXIOUS OR WORRIED FOR NO GOOD REASON

A. NO, NEVER
B. NOT VERY OFTEN
C. YES, SOME OF THE TIME
D. YES, MOST OF THE TIME

I HAVE FELT SCARED OR PANICKY FOR NO GOOD REASON

A. NO, NEVER
B. NOT VERY OFTEN
C. YES, SOME OF THE TIME
D. YES, MOST OF THE TIME

THINGS HAVE BEEN GETTING TO ME

A. NO I HAVE BEEN COPING WELL AS EVER
B. NO MOST OF THE TIME I HAVE COPED QUITE WELL
C. YES SOMETIMES I HAVEN'T BEEN ABLE TO COPE AT ALL
D. YES MOST OF THE TIME I HAVEN'T BEEN ABLE TO COPE AT ALL

I HAVE BEEN SO UNHAPPY THAT I HAVE HAD DIFFICULTY SLEEPING

A. NO, NEVER
B. NOT VERY OFTEN
C. YES, SOME OF THE TIME
D. YES, MOST OF THE TIME

I HAVE FELT SAD OR MISERABLE

A. NO, NOT AT ALL
B. ONLY OCCASIONALLY
C. YES, QUITE OFTEN
D. YES, MOST OF THE TIME

THE THOUGHT OF HARMING MYSELF HAS OCCURRED TO ME

A. NEVER
B. HARDLY EVER
C. SOMETIMES
D. YES, QUTE OFTEN

Review of Systems

Please circle any problems you are having: or ____ No complaints at this time

Constitutional: ____ No complaints

- Fever, fatigue, significant weight loss, ___lbs., significant weight gain, ___lbs.
- Additional info _____

Cardiovascular: ____ No complaints

- Chest pain, irregular heartbeat, difficulty breathing
- Additional info _____

Gastrointestinal: ____ No complaints

- Heartburn, difficulty swallowing, nausea, vomiting, abdominal pain, bowel movement changes, diarrhea, constipation, rectal bleeding
- Additional info _____

Genitourinary: ____ No complaints

- Blood in urine, abnormal bleeding, flank pain, trouble urinating, urinary frequency, urinary urgency, painful urination, frequent urination at night, incontinence, rash, lesion, discharge, vaginal odor, vaginal itching
- Additional info _____

Endocrine: ____ No complaints

- Thyroid disease, type 2 diabetes
- Additional info _____

Menstrual: ____ No complaints ____ Currently no period due to: _____

- Irregular timing, light flow, heavy flow, severe cramping, mood swings, irritability, tension/ anxiety, depression,
  breast pain/ tenderness, bloating, feeling out of control/ overwhelmed
- Additional info _____

Menopausal: ____ No complaints

- Hot flashes, night sweats, vaginal dryness, memory loss, difficulty concentrating
- Additional info _____

Sexual: ____ No complaints

- Decreased sex drive, painful intercourse, vaginal tightness, vaginal discomfort, bleeding w/ intercourse
- Additional info _____

Psych: ____ No complaints

- Depression, anxiety, alcoholism, sleep disturbances, not situational, chronic, not chronic
- Additional info _____

Breast: ____ No complaints

- Breast lump, breast mass, nipple discharge, skin changes, breast pain ___left ___right
- Additional info _____

Pain: ____ No complaints

- Chronic pain: neck, back, joint, other
- Additional info _____

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PATIENT FINANCIAL DISCLOSURE

The following information is provided to all patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements. Please read carefully and ask one of out team members if you have any questions regarding these policies.

Please initial by each policy:

_____ Insurance is billed as a courtesy; however, all charges, regardless of insurance coverage are the patient's responsibility. We will expect payment for your portion at the time of service and may be paid by cash or credit card. This includes co-pays, co-insurance, deductibles, and estimated costs as necessary. We ask that if your insurance company has not paid us within 45 days that you follow up with them. Our office contracts with most insurance carriers.

_____ If you have Soonercare, and you have other commercial insurance, you are required by law to notify Soonercare of this coverage. Failure to do so could result in denial of claims making you fully responsible for the billed charges. Federal and State law requires us to file with the primary insurance carrier before filing your claim with Soonercare, whether it is patient preference or not.

_____ If you are seen for both wellness and other problems, we will use proper coding which may result in a charge for both services. Your individual insurance policy will determine how your insurance will pay if you will be responsible for any portion. We will make every effort to bill each visit with the proper diagnosis and procedure codes according to the national coding guidelines.

_____ Injections such as Lupron, Makeena, and Depo Provera and other specialized products or services may need to be pre-authorized with your insurance prior to services. Please check with staff to make sure the proper authorizations are completed before services are rendered, otherwise the patient will be responsible for any charges denied by your insurance.

_____ Birth control devices such as Mirena, Skyla, Paragard, Liletta, Kyleна, and Nexplanon may require a deposit before services are rendered depending on your insurance. The deposit would be returned to you after payment from your insurance company is received by our office, which may take up to 60 days.

_____ For surgical care, we will pre-certify your insurance and obtain the estimated costs for the procedure. This amount is due one week prior to the scheduled date of your procedure and is only an estimate. If the procedure results in additional charges, these fees will be billed to you. We ask that you pay your balance within 30 days following receipt of billed charges. We accept cash or credit cards for payment.

_____ Laboratory testing are routinely sent to Diagnostic Laboratory of OK (DLO), if your insurance requires your lab test to be sent to a different lab, you must let a staff member know before services are performed. Additionally, lab testing that is NOT routine (such as Yeast or STD testing) is usually subject to your deductible and co-insurance. You will receive separate invoices from the lab if you have a balance. Please call the lab directly if you have any questions about your bill. We only order the proper test necessary in order to treat your condition.

_____ There may be a $25 charge if you NO SHOW or Cancel an appointment in less than 24 hours. This fee is the responsibility of the patient and will not be billed to your insurance.

_____ Paprework (such as FMLA or short term disability) will be completed 7-10 business days from the day it is received in our office. The charge for each form is $25, payable in full when the form is turned in, we will not bill this to your insurance.

I have read and understand the above information and agree to comply with these financial policies.

Patient Signature: _____ Date: _____

3330 NW 56th St., Ste. 612 * Oklahoma City, OK * 73112
(405) 605-7757

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PATIENT PRIVACY PRACTICES ACKNOWLEDGEMENT

As described in the Notice of Privacy Practices there are individuals and entities to which Victoria Mills, DO is legally authorized to discuss my health information. In addition, I authorize the following individual(s) to have access to my health information:

_____

_____

_____

_____

Description of Access Allowed:

_____

_____

_____

Patient Signature: _____ Date: _____

Victoria Mills, DO is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights regarding your health information. Please sign below to acknowledge that you have received a copy of the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Victoria Mills, DO.

Name (printed): _____

Patient's signature: _____ Date: _____

Name of personal representative (if appropriate): _____

Signature of personal representative (if appropriate): _____ Date: _____

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