Mills
Obstetrics & Gynecology

NEW GYNECOLOGY 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: ______

HAVE YOU HAD ROUTINE LABS CHECKED THIS YEAR? NO YES

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: ____

DO YOU HAVE PROTECTED SEX? ALWAYS USUALLY NO

PAP SMEAR/ MAMMOGRAM/ BONE DENSITY/ COLONOSCOPY HISTORY

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: ________________

HAVE YOU HAD A BONE DENSITY TEST? NO YES IF YES, DATE: ________________ RESULT: ________________

HAVE YOU HAD A COLONOSCOPY? 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: LIVE ALONE WITH OTHERS

DO YOU WEAR SEATBELTS ROUTINEY? NO YES

DO YOU ROUTINELY USE SUNSCREEN? NO YES

IS A BLOOD TRANSFUSION ACCEPTABLE IN AN EMERGENCY? NO YES

DO YOU HAVE AN ADVANCED DIRECTIVE? NO YES

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

DO YOU HAVE ANY OCCUPATIONAL HEALTH RISKS? 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: _____________

DO YOU PERFORM MONTHLY SELF BREAST EXAMS? NO YES

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 ____

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 ____________________

PATIENT NAME:_______________________________________ DATE OF BIRTH: _______________________

PAST SURGICAL HISTORY (NOT OB/GYN) ______ NONE

SURGERIES/ HOSPITALIZATIONS	YEAR
____	______________
____	______________
____	______________
____	______________

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 SIGNATURE: ____ DATE: ___________________________

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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.

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, Kyleena, 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.

Paperwork (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 * FAX (405) 594-2495

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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