# *Central Oregon OB/Gyn*

Date_____

Patient Name_____Date of Birth_____

Married_____ Single_____ Widowed____ Divorced____

Mailing Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____
OK to leave detailed message on voicemail? _____Yes ____No

Email_____Primary Care Doctor_____

Emergency Contact_____Relationship_____

Emergency Contact Phone_____

Pharmacy Name_____Location_____

# HEALTH HISTORY FORM

Name:_____ Age:_____ Birthdate:_____
Home/Cell Phone:_____ Work Phone:_____
Primary Physician:_____ Physician that referred you:_____
Reason for visit today:_____

## Medication

| Medication Name & Dose | Allergies & Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Gynecological & Obstetrics History

When was the first day of your last menstrual period?_____
Age at your first period? _____ Frequency?_____ Flow_____
Any associated symptoms with your period? _____
_____
Do you have menstrual cramps/pain?_____How severe? Mild___ Moderate___ Severe___
Do you ever bleed between periods? _____ After intercourse?_____ Since Menopause?_____
What do you use for contraception? _____

Have you ever had:

| | | |
|---|---|---|
| _____Fibroids | _____Genital Herpes | _____Bacterial Vaginosis |
| _____Endometriosis | _____Gonorrhea | _____Yeast Infection |
| _____Ovarian Cysts | _____Chlamydia | _____Hot Flashes |
| _____Endometrial Polyps | _____Genital Warts | _____Vaginal Dryness/Itching |
| _____Pelvic Inflammatory Disease | _____Syphilis | _____Mood Swings |

Have you gone through menopause? _____No ____Yes What age?_____
Date of last pap smear:_____ Normal? ____Yes ____No
Have you ever had an abnormal pap smear? __Yes __No Did you have: cryo colpo leep cone
Date of last mammogram:_____Normal?_____Yes____No Self breast exam?_____Yes____No

Total number of pregnancies_____Number of living children_____Number of miscarriages_____
Ectopic pregnancies_____ Terminations_____ Difficulty getting pregnant?_____Yes_____No

| **Date of Delivery:** | **Infant Weight:** | **Length of Labor** | **Vaginal or C-section** | **M/F** |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

## Sexual History

Are you sexually active?____Yes____No Do you ever have pain with intercourse?_____Yes____No
Is your sex life satisfactory?___Yes___No Sexual preference? ____Male _____Female
Any history of physical, emotional or sexual abuse?_____Yes_____No

## Surgical History

Have you ever had any surgeries?____Yes____No If yes, please indicate what kind and the date of surgery.

_____ _____
_____ _____
_____ _____
_____ _____

****PLEASE TURN PAGE OVER TO COMPLETE QUESTIONNARE****

## Social / Personal History

Do you smoke cigarettes?____Yes____No If yes, how many a day?_____
Do you drink beer, wine, or liquor? ___Yes___No If yes, how often?_____
Have you, or do you use marijuana, cocaine, crack or other street drugs? ____Yes____No
Have you ever used IV drugs?_____Yes_____No Do you have tattoos? ____Yes_____No
Have you ever been physically or sexually violated?_____Yes_____No
If yes, does this affect your current relationship?_____Have you had counseling, or would you like a referral for counseling?_____
Do you have any questions or concerns about your sexual orientation or preference?_____
Have you ever had a blood transfusion? ___Yes___No If yes, when & where?_____

## Urinary Problems

_____Urine loss with coughing
_____Urine loss with urgency
_____Urinary urgency
_____Urinary frequency
_____Wear urinary incontinence products
_____Pain with urination
_____Blood in urine
_____Bladder infection
_____Difficulty Urinating
_____Bed wetting
_____Up at night to urinate (_____times)
_____Uncontrollable

## Medical History

_____Diabetes
_____High Blood Pressure
_____Stroke
_____Arthritis
_____Clotting disorder/DVT
_____Tuberculosis
_____Asthma
_____Anemia
_____Bleeding problems
_____Liver disease
_____Osteoporosis
_____Gallbladder disease
_____Hepatitis (B___C___)
_____Depression/Anxiety
_____Cancer
_____Multiple Sclerosis
_____Parkinson's
_____Alzheimer's
_____Fibromyalgia
_____HIV/AIDS
_____Thyroid

## Family History

Has your Mother, Father, Brother/Sister(s) or Grandparents had any of the following conditions? Please indicate yes or no and if yes, please write which relative next to the condition.

_____Breast cancer
_____Ovarian cancer
_____Uterine cancer
_____Colon cancer
_____Diabetes
_____Birth defects
_____High Blood Pressure
_____Heart disease
_____Stroke
_____Parkinson's
_____Clotting disorder/DVT
_____Did your mother take DES when pregnant with you?
_____Alzheimer's
_____Alcohol/Drug abuse
_____Seizure disorder
_____Psychiatric disorders
_____Sickle cell

## Have you recently experienced

_____Constipation
_____Diarrhea
_____Soiling pants w/ BM
_____Blood in stool
_____Vomiting blood
_____Vaginal dryness
_____Difficulty breathing
_____Sudden weight change (up/down)
_____Chest Pain
_____Heart Attack
_____Skin problems
_____Abnormal hair growth
_____Headaches
_____Change in vision
_____Appetite change
_____Weakness/Numbness
_____Suicidal thoughts
_____Swollen glands
_____Breast lumps
_____Hoarseness
_____Coughing up blood
_____Change in hearing

Patient Signature_____Date_____

**CENTRAL OREGON OB/GYN**
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## HIPAA Privacy and Release of Information Authorization

I, _____, hereby authorize CENTRAL OREGON OB/GYN and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____

Patient Printed Name Date

_____

Patient Signature

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## HIPPA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

_____ _____

_____ _____

Contact Information: _____

_____

_____ _____

Name of Individual Giving this Authorization Date of Birth

_____ _____

Signature of Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. 164.524