COMPLETE WOMEN CARE
BEST IN WOMEN'S HEALTH

Dear Patient,

Thank you for choosing Complete Women Care!

We are committed to providing the highest quality OB/GYN care for women of all ages in an atmosphere of genuine caring and with a commitment to developing and maintaining an outstanding patient/doctor relationship.

OUR OFFICES

As a patient of Complete Women Care you can choose to be seen at any of our OB/GYN Offices.

CWC Long Beach I 3711 Long Beach Blvd. Suite 700, Long Beach, CA 90807
CWC Lakewood I 3650 E South St., Suite 403, Lakewood, CA 90712
CWC Rolling Hills Estates I 550 Deep Valley Dr., Suite 279, Rolling Hills Estates, CA 90274

Our Patient Coordinators are here for you 24/7. We available via phone 562 634 8812 and chat on our website www.completewomencare.com.

GYN EMERGENT CARE CENTER

If you have an early pregnancy or gynecological emergency, you can walk-in to our GYN Emergent Care Center 24/7. In case an emergency surgery is needed, our GYN Surgical Institute team is always ready to provide the best care possible. If you feel you have a life-threatening emergency please always call 911. In case you need to speak to one of our doctors please call our office 24/7 and our patient Coordinators will assist you.

GYN Emergent Care Center I Open 24/7
3711 Long Beach Blvd., Suite 101B, Long Beach, CA 90807

YOUR PATIENT PORTAL

If you already have received an email with instructions on how to access your Patient Portal Account, please log in and fill out the GYN History Form. If not, after your first visit, your Patient Portal Account will be created, and you will be able to exchange messages with our practice, review and pay bills, request appointments, research health topics, review personal health information, complete and update medical forms, and update your profile and contact information online. You can access your Patient Portal Account any time by visiting our website www.completewomencare.com.

Cordially Yours,

The Doctors and Staff of Complete Women Care

NOTICE OF PRIVACY PRACTICES

PATIENT COPY

Effective August 18, 2016

This notice describes how your medical information you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is being provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes under what circumstances our medical practice (hereto referred as "the Practice") may use and disclose medical information about you to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. Your medical information (i.e., "protected health information" for purposes of HIPAA) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition. We are required by law to maintain the privacy of your medical information and we must abide by the terms of this notice.

In this notice, we provide descriptions of the different ways that we may use and disclose your medical information. In some cases, an example is provided to describe the types of uses and disclosures of your medical information that may be made by us.

In addition to the privacy protections provided under federal law (which are described in more detail below), and except in certain limited circumstances, California Law requires us to obtain your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information if you qualify as a patient that:

- Suffers from a sexually transmitted disease;
- Is HIV+ or has Acquired Immune Deficiency Syndrome (AIDS);
- Suffers from a mental disorder;
- Has a problem with substance abuse;
- Is eligible to receive benefits for the State of California for certain developmental disabilities or mental retardation;
- Receives rehabilitative services through the California Medi-Cal program;
- Is eligible to receive certain other benefits through California's Medi-Cal program

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get list with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at any time.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in both state and federal law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions.
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy & security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint, contact our Privacy Officer at the address below. All complaints must be submitted in writing. You will not be penalized for filing a complaint, and we will seek to deal with all complaints in a reasonable and efficient manner.

Privacy Officer:

Natalie Ugalde, HIPAA Compliance Officer
Complete Women Care, Inc.
3711 Long Beach Blvd., Suite 700
Long Beach, CA 90807
Phone: 562 424 8422

PATIENT COPY

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____

Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

This agreement has two copies. One signed copy of this document is to be given to Patient. The second one is to be files in Patient's medical records

_____

Authorized representative's Signature

_____ _____

Patient or Patient Representative's Signature Date

_____

Print Patient's Name

_____

If representative, Print Name and Relationship to Patient

COMPLETE WOMEN CARE

3711 Long Beach Blvd., # 700 I Long Beach I CA I 90807

3650 E South St., # 403, Lakewood I CA I 90712

550 Deep Valley Drive, # 279, Rolling Hills Estates I CA I 90274

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____

Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

This agreement has two copies. One signed copy of this document is to be given to Patient. The second one is to be files in Patient's medical records.

_____

Authorized representative's Signature

_____ _____

Patient or Patient Representative's Signature Date

_____

Print Patient's Name

_____

If representative, Print Name and Relationship to Patient

COMPLETE WOMEN CARE

3711 Long Beach Blvd., # 700 I Long Beach I CA I 90807

3650 E South St., # 403, Lakewood I CA I 90712

550 Deep Valley Drive, # 279, Rolling Hills Estates I CA I 90274

FINANCIAL POLICY

A COPY OF THIS FORM WILL BE CONSIDERED AS ACCEPTABLE AS THE ORIGINAL.

1. **LIFETIME AUTHORIZATION OF RESPONSIBLE PARTY**

I authorize direct payment of medical benefits to Complete Women Care, Inc. for any and all services rendered to me. If any insurance claim is failed on my behalf, I understand that I am fully responsible for any charges not covered or paid by my insurance carrier. This authorization does not imply in any way that Complete Women Care, Inc. will accept insurance benefits as payment in full. Any charge incurred to recover unpaid debts relating to my account will be my responsibility.

_____ Initials

2. **CREDIT CARD ON FILE**

(Policy added because your insurance requires us to collect your copays and deductibles.)
I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining is to be paid by me. I agree that Complete Women Care may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $200.00, I'll receive a courtesy call prior to my card being charged.

_____ Initials

3. **FINANCIAL RESPONSIBILITY FOR ANY DEDUCTIBLES (MEDI-CAL)**

As of March 1, 2015, we will no longer accept Medi-Cal as a primary or a secondary payer. All patients with Medi-Cal as a secondary policy will be financially responsible for any deductibles or co-insurance that their primary policy deems patient responsibility.

_____ Initials

4. **PHYSICIAN-PATIENT COMMUNICATION AGREEMENT**

I give my permission for the staff of Complete Women Care, Inc. to leave messages on my telephone answering machine regarding my health care, insurance benefits, and/or regarding my appointment. As a service to our patients, we provide a courtesy appointment reminder call and other important calls that may be placed using a pre-recorded message. By providing your cell phone or any other contact number, you consent to receiving such calls at that number.

_____ Initials

5. **NOTICE OF RETURNED CHECK FEE**

I understand if my check payment is returned unpaid, I'll be assessed a $25 return fee in addition to my original payment amount.

_____ Initials

6. **REQUEST FOR CERTAIN FORMS**

Forms that are requested by a patient take a considerable amount of staff time to process, and often take away from the time spent with a patient. To offset this cost, I understand that I will incur a charge of $25/form for EDD, Work Disability, or other government related forms. Forms that require a company letterhead, such as a 'return to work' authorization will incur a charge of $15/form, and forms for WIC will incur a charge of $5/form. I further authorize CWC to charge my credit card on file in the event I don't pay for these forms by the required due date.

_____ Initials

7. **LAB WORK**

Complete Women Care will run some of the lab testing in-house. Labs that can't be ran in-house will be sent out to Primex, PathMD, Quest or LabCorp. You will receive a separate bill for any third-party lab services. In some situations, your insurance company dictates that we send out lab work to their preferred lab. It's your responsibility to inform our staff of your preferred lab. If you would like your send-out lab work to be sent to a specific lab, i.e., Quest or LabCorp, you must tell us on every visit.

_____ Initials

8. **NOTICE OF FAILED APPOINTMENT FEE**

I acknowledge that if I fail to cancel my appointment within 48 hours prior to my scheduled time, I may be assessed a no-show fee of $40. Complete Women Care, Inc. considers a "failed appointment" any time a patient has not given an advanced cancellation notice or has failed to arrive within 20 minutes of her appointment time.

_____ Initials

9. **UNPAID COPAY AT TIME OF SERVICE**

I agree to pay a $10.00 administrative fee if I fail to pay my copay at the time of service.

_____ Initials

My signature below acknowledges that I have read and accept the above statements and any attached documents.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES & ARBITRATION AGREEMENT

The practice reserves the right to modify the privacy practices outlined in this notice.

I, the undersigned, have received a copy of the Notice of Privacy Practices and the Arbitration Agreement.

_____ _____

Print Patient's Name Date

_____ _____

Patient or Patient Representative's Signature If representative, Print Name and Relationship to Patient

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

ATTEMPT TO OBTAIN ACKNOWLEDGEMENT

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on _____.

The acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment
- ☐ The patient declined to sign the acknowledgement
- ☐ Other

_____ _____

Print Patient's Name Date

_____ _____

If representative, Print Name and Relationship to Patient Patient or Patient Representative's Signature

_____

Name of Staff Member

PATIENT INFORMATION RECORD

It's our pleasure to welcome you to Complete Women Care. To provide the best medical care, it's essential that we have your up-to-date information. Please print and complete all spaces and signatures below prior to your initial examination.

Date:		Updated:							
PATIENT INFORMATION									
First Name:		Last Name:							
Date of Birth:	Male		Female		SS#	Ethnicity			
E-mail:		Phone:							
Address:				Apt #:					
City:		State:		ZIP code:					
EMPLOYER INFORMATION									
Employer:				Occupation:					
Address:									
City:		State:		ZIP code:					
Work Phone:									
SPOUSE INFORMATION									
First Name:		Last Name:							
Date of Birth:				SS#:					
Employer:									
Employer Address:				Suite #:					
City:		State:		ZIP code:					
Home/Cell Phone:		Work Phone:							
EMERGENCY CONTACT									
First Name:		Last Name:							
Phone:		Date of Birth:		Relationship:					
PRIMARY INSURANCE COMPANY									
Insurance Company Name:					Group		Private		
Insured Name:									
Plan / Policy#:		Other ID #:							
Insurance Co. Phone:									
Insurance Co. Address:				State:		ZIP code:			
SECONDARY INSURANCE COMPANY									
Insurance Company Name:					Group		Private		
Insured Name:									
Plan / Policy#:		Other ID #:							
Insurance Co. Phone:									
Insurance Co. Address:				State:		ZIP code:			
WHAT MADE YOU CHOSE US?									
o Physician referral	o Family/Friend recommendation	o Yelp review	o Google review	o Insurance	o TV	o Online Search	o Other		
Referral Name:									
Referral Phone Number:		Referral E-mail:							

MEDICAL HISTORY

First Name:	Last Name:
Date of Birth:	Updated:

PLEASE DESCRIBE MAIN REASON FOR YOUR VISIT:

MEDICAL HISTORY OF THE PROBLEM

Date when the problem first started:

Any medications/treatment that help? Yes | | No | |

If yes, please list:

Please describe any previous treatment for this problem:

DO YOU HAVE ANY SURGICAL HISTORY? IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Type:	When:	Where:	Pathology results (if known):

ARE YOU CURRENTLY TAKING ANY MEDICATION? IF YES, PLEASE LIST.

Name:	Dose:

HAVE YOU EVER RECEIVED HPV IMUNIZATION?

Yes | | No | | If yes, when? | |

DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE LIST.

Type:	Since:

HAVE YOU OR YOUR FAMILY MEMBERS EVER HAD ONE OF THE FOLLOWING:

	No		Yes		Yes, family members
Unusual Headaches / Nervous Disorders					
Convulsions or Fainting Spells					
Eye, ear, nose, or throat problems					
Thyroid problems					
Breast problems					
Heart condition					
High blood pressure					
Lung disorder or asthma					
Stomach, bowel, or gallbladder problems					
Kidney or bladder problems					
Diabetes					
Jaundice or hepatitis					
Anemia or other blood disorder					
Cancer					
Birth defects or inherited diseases					
Other:					

MEDICAL HISTORY

DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING?									
Breast Cancer		Ovarian Cancer		Uterine Cancer		Cervical Cancer			
Hereditary diseases, e.g. Down's Syndrome	No		Yes						
If yes, please describe:									

SOCIAL HISTORY									
Marital status	Single		Married		Divorced		Widowed		
Do you take recreational drugs?	No		Yes						
Do you consume alcohol?	No		Yes						
Do you smoke?	No		Yes		If yes how many cigarettes per day?				
Have you have any blood transfusions?	No		Yes						

INFERTILITY PATIENTS					
Ovulation induction	Yes		No		If yes, please describe:
** The following data refers to your partner*					
Previous marriages?	No		Yes		
Previous children?	No		Yes		
Health status:					

MENSTRUAL HISTORY							
How old were you when you got your first period?					Date of last period?		
How long does your period usually last?	days	How often do you have your period?					
STD	Yes		No		If yes, what type?		
Contraception:	Yes			No			
Date of last PAP:	History of abnormal PAP?	If yes, explain.					
If yes, what treatment?			No				
Pelvic inflammatory disease:	Yes	No					
If yes, please describe:							

SEXUAL HISTORY							
Coital frequency:			No				
Do you have painful intercourse?	Yes		No				
Do you use any lubricant/douche?	Yes						
Other issues/concerns:							

SEXUAL HISTORY					
Homosexual		Bisexual		Heterosexual	

PREGNANCY HISTORY (INCLUDING MISCARRIAGES)					
Year	Weeks Pregnant	Weight of Newborn	Sex	Complications	Vaginal or C Section delivery

PHARMACY	
Pharmacy Name:	Pharmacy Phone Number:

PATIENT PROVIDERS (To serve you better, please be sure to list all the names of all physicians, internists, nurse practitioners etc., taking care of you.)

Physicians Name:	Specialty:	Phone number:
Physicians Name:	Specialty:	Phone number:
Physicians Name:	Specialty:	Phone number:

BLADDER HEALTH HISTORY

Do you ever leak urine during a cough, sneeze, laugh, or other physical activity?				Yes	No
What other types of activities cause this to occur?					
Immediately after finishing urinating, do you feel the sensation of needing to urinate again?				Yes	No
Do you sometimes dribble just prior to or just after urination?				Yes	No
Do you leak spontaneously without warning?				Yes	No
Do you have sudden urges to urinate?				Yes	No
Do you leak if you have a sudden urge?				Yes	No
Do you use protective pads or diapers?				Yes	No
How many per day?	None	1-3	4 +	Type:	
Have you tried Kegel exercises, biofeedback, or other non-surgical means of controlling incontinence?				Yes	No
Do you have frequent urinary tract infections?				Yes	No
Have you ever had blood in your urine?				Yes	No
Do you have pain when you urinate?				Yes	No
Does your urinary problem interfere with your daily activities?				Yes	No
Does your urinary problem interfere with your sexual activities?				Yes	No
Do you get up at night to urinate?				Yes	No
Do you ever leak urine at night?				Yes	No
Do you have children?				Yes	No
Have you completed your child-bearing?				Yes	No
Were your children delivered by C-Section?				Yes	No
Have you ever had a gynecological or urological surgical procedure, such as bladder neck suspension or hysterectomy?				Yes	No
If you had a hysterectomy, was it preformed through an open incision?				Yes	No
Were the ovaries removed at the time of hysterectomy?				Yes	No
If yes, are you taking any hormone replacement therapy?				Yes	No
Have you had radiation treatment of the pelvis?				Yes	No
Do you currently smoke or have you smoked in the past?				Yes	No
What medications are you currently taking?					
How many times do you experience incontinence episodes in a day?	0	1-3	4+		
How long ago were the first instances of incontinence?					