OFFICE USE ONLY:
DR._____

Wt._____Ht._____

BP_____

Lakeside Doctors
Gynecology & Obstetrics

New Patient Form

Patient History Questionnaire

1. Marital Status: (Circle One) Single Married Long Term Relationship Divorced Widowed

2. Reason for this visit: _____

3. Referring Physician: _____

4. Preferred phone number: _____

5. Pharmacy Address: _____ Pharmacy Phone: _____

6. Primary Care Physician: _____ Address: _____ Phone:_____

Current Medications (Please list all medications, vitamins and supplements.)

Medication	Dose	Frequency

Are you allergic to any medications? ☐ No ☐ Yes

List Medicine and Reaction: _____

_____

Vaccine History

TDAP ☐ NO ☐ YES If yes, Date of Vaccination: _____

Pneumonia ☐ NO ☐ YES If yes, Date of Vaccination: _____

Gardasil (HPV) ☐ 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

1. Age of first period_____ **2.** Do you have cramps? ☐ NO ☐ YES

3. If your menstrual periods are regular; periods start every _____ days

4. If your menstrual periods are irregular; periods start every _____ to_____ days (e.g., 12 to 60)

5. First day of last menstrual period: _____ (m/d/year) **6.** Is your period flow: ☐ Light ☐ Moderate ☐ Heavy

7. If postmenopausal, at what age? _____

Pap Smear/ Mammogram/ Bone Density/ Colonoscopy History

1. Date of last pap smear: _____ **2.** Have you had treatment for abnormal smears? ☐ NO ☐ YES

3. Have you had: Cryotherapy? If so, when? _____ Laser? If so, when? _____

Cone Biopsy? If so, when? _____ Loop Excision (LEEP)? If so, when? _____

4. Have you had a Mammogram? ☐ NO ☐ YES Date: _____Result: _____Location:_____

5. Have you had a Bone Density: ☐ NO ☐ YES Date: _____Result: _____Location: _____

6. Have you had a Colonoscopy? ☐ NO ☐ YES Date: _____Result: _____Location: _____

Pregnancy History (All pregnancies) **Have never been pregnant** ☐

OBSTETRICAL HISTORY INCLUDING MISCARRIAGES, ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

# of pregnancies:	**# of full term births:**	**# of pre-term births:**	**# of pregnancy losses:**	**# of living children:**	**# of induced abortions:**

Year	Place of delivery	Duration Pregnancy	Hours of Delivery	Type of Pregnancy	Complications Mother/Infant	Child's Sex	Birth Weight	Present Health

Family History

Illness	**Relation**	**Maternal**	**Paternal**	**Illness**	**Relation**	**Maternal**	**Paternal**
1. AIDS (HIV)	_____	☐	☐	**11.** High Cholesterol	_____	☐	☐
2. Anemia/ Blood Disorder	_____	☐	☐	**12.** Kidney Disease	_____	☐	☐
3. Anesthesia Complications	_____	☐	☐	**13.** Lung Cancer	_____	☐	☐
4. Birth Defects	_____	☐	☐	**14.** Osteoporosis	_____	☐	☐
5. Breast Cancer	_____	☐	☐	**15.** Ovarian Cancer	_____	☐	☐
6. Colon Cancer	_____	☐	☐	**16.** Rheumatoid Arthritis/ Lupus	_____	☐	☐
7. Diabetes	_____	☐	☐	**17.** Stoke	_____	☐	☐
8. Endometrial Cancer	_____	☐	☐	**18.** Uterine Cancer	_____	☐	☐
9. Heart Disease	_____	☐	☐	**19.** Other	_____		
10. High Blood Pressure	_____	☐	☐				

Social History

1. Do You Smoke: ☐ NO ☐ YES _____packs/day ☐ Former Smoker _____ packs/day _____ years

2. Occupation: _____

3. Religion: _____

4. Stress Level: (circle one) ☐ Low ☐ Medium ☐ High

5. Diet: Regular Vegetarian Other:_____

6. Exercise: Type: _____ How Often:_____

7. Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

8. Do you have sex with: ☐ Men ☐ Women ☐ Both

9. Sexually Active? ☐ NO ☐ YES

10. Has there been a new sexual partner in the last year? ☐ NO ☐ YES

11. Is sexual intercourse painful? ☐ NO ☐ YES

12. Current Birth Control Method: _____

13. Do You Drink Alcohol: ☐ NO ☐ YES How Many Drinks/Week? _____

14. Caffeine Intake: (circle one) None Occasional Moderate Heavy

15. Do You Use Illicit Drugs: ☐ NO ☐ YES Type _____Last Used _____

16. Number of Hours of Sleep Each Night: _____hrs.

Past Obstetrical/Gynecological Surgeries

Check any that apply: or ☐ NONE

SURGERY	YEAR	SURGERY	YEAR
☐ D&C	_____	☐ L Cyst(s) Removed Ovarian	_____
☐ Hysteroscopy	_____	☐ R Cyst(s) Removed Ovarian	_____
☐ Infertility Surgery	_____	☐ L Ovary Removed	_____
☐ Laparoscopy	_____	☐ R Ovary Removed	_____
☐ Tuboplasty	_____	☐ Cesarean Section	_____
☐ Tubal Ligation	_____	☐ Myomectomy	_____
☐ Hysterectomy-Abdomen	_____	☐ Vaginal or Bladder Repair	_____
☐ Ovarian Surgery	_____	☐ Other_____	

Past Surgical History (Not OB/GYN)/ Hospitalizations

Please List All Surgeries: **OR** ☐ **NONE**

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

Past Medical History ☐ NONE

☐ AIDS (HIV)
☐ Anemia/Blood Disorder
☐ Anesthesia Complications
☐ Anxiety Disorder
☐ Arthritis/Lupus
☐ Asthma
☐ Birth Defects or Inherited Disease
☐ Blood Transfusion
☐ Breast Cancer
☐ Breast Problem: Type _____
☐ Cancer: Type _____
☐ Chlamydia/Gonorrhea
☐ Depression
☐ Diabetes: Type _____
☐ Endometriosis
☐ Female/Sexual Problems
☐ Headaches/Migraines
☐ Heart Conditions
☐ Hepatitis: Type _____
☐ Herpes (HSV)
☐ High Blood Pressure
☐ High Cholesterol
☐ Infertility
☐ Kidney or Bladder Problems
☐ Liver Disease
☐ Lung Disease: Type _____
☐ Other _____
☐ Ovarian Cancer
☐ Psychiatric Illness: Type _____
☐ Rheumatic Fever
☐ Seasonal Allergies
☐ Sexual Abuse/Domestic Violence
☐ Stomach, Bowel or Gall Bladder Problems
☐ Syphilis
☐ Thyroid Problems
☐ Tuberculosis
☐ Varicosities (Varicose Veins)

Review of Systems

Please circle any problems you are having: ☐ NO COMPLAINTS AT THIS TIME

Constitutional: ☐ NO COMPLAINTS

- fever, fatigue, significant weight loss (____lbs.), significant weight gain (_____lbs.)
- **Additional information**:_____

Cardiovascular: ☐ NO COMPLAINTS

- chest pain, irregular heartbeat, difficulty breathing
- **Additional information**:_____

Gastrointestinal: ☐ NO COMPLAINTS

- heartburn, difficulty swallowing, nausea, vomiting, abdominal pain, bowel movement changes, diarrhea, constipation, rectal bleeding
  Additional information:_____

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 information: _____

Endocrine: ☐ NO COMPLAINTS

- thyroid disease, type 2 diabetes
- **Additional information**: _____

Menstrual: ☐ NO COMPLAINTS ☐ Currently No Period Due To: _____

- irregular timing, light flow, heavy flow, severe cramping, mood swings, irritability, tension/anxiety, depressed mood, breast pain/tenderness, bloating, feeling out of control/overwhelmed
  Additional information: _____

Menopausal: ☐ NO COMPLAINTS

- hot flashes, night sweats, vaginal dryness, memory loss, difficulty concentrating
- **Additional information**:_____

Sexual: ☐ NO COMPLAINTS

- decreased sex drive, painful intercourse, vaginal tightness, vaginal discomfort, bleeding w/ intercourse
- **Additional information**: _____

Psych: ☐ NO COMPLAINTS

- depression, anxiety, alcoholism, sleep disturbances, not situational, chronic, not chronic
- **Additional information**: _____

Breast: ☐ NO COMPLAINTS

- breast lump, breast mass, nipple discharge, skin changes, breast pain ☐ LEFT ☐ RIGHT
- **Additional information**: _____

Pain: ☐ NO COMPLAINTS

- chronic pain: neck, back, joint, other
- **Additional information**: _____

Lakeside Doctors

Patient Information / Disclosure Agreement

Doctor: _____

Patient Last Name: _____First Name: _____Middle Init: _____

Address: _____ City: _____State: _____Zip: _____

Home #: _____Work#: _____Ext: _____Mobile: _____

Date of Birth: _____SS#: _____-_____-_____Marital Status: _____

E-mail: _____Race: _____

Primary Care Physician:_____ Phone Number:_____

Pharmacy:_____ Pharmacy Address: _____

Employer: _____Occupation: _____

Emergency Contact: _____Relationship: _____Phone #: _____

All Lab/blood work will be sent to the hospital's contracted lab.

REASON FOR TODAY'S VISIT

□ **Routine Preventative Exam:** (I have no medical complaint or problem of which I am aware.) **Medicare will not cover.**

□ **Routine Preventative Exam AND the Following Problem** that I wish to be evaluated/ treated:

_____

□ **I have a Problem/ Complaint** that I wish to have evaluated/ treated. My Chief Complaint Is:

_____

Physicians of NW Oklahoma City, LLC (Arielle Allen, Susan L. Chambers, Elizabeth A. Pinard, Jennifer K. Nelson, Valerie A. Engelbrecht, Dana G. Stone, Margaret A. Hall, D. Nelson Fong, Whitney C. Driver, Lisa Wasemiller-Smith, and William Miller) are owners of Lakeside Women's Hospital. We refer patients there because it is convenient and efficient for patients, and the quality of care is excellent. We believe that patients have a choice in the selection of health care facilities. If you wish to use another facility, please let us know.

I hereby authorize the physicians of the Lakeside Doctors to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Lakeside Doctors all payments for medical services rendered to myself or my dependents. I understand that the information authorized for release may include information, which may be considered a communicable, or venereal disease.

Lakeside Women's Hospital has arranged for one or more physicians to be on on-site at the Hospital and available to respond for medical emergencies during most hours of operation. However, we cannot guarantee that a physician will be present at the Hospital at all times. The Hospital has taken certain measures to ensure that qualified and properly trained medical personnel are available to respond to any medical emergency that may arise when a physician is not present at the Hospital.

I agree to pay for any and all medical services I receive from the doctor that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf (if contracted). I will pay these charges upon written/ verbal notice of their refusal. Failure of your insurance company to pay within 45 days of claim filing date will be considered a refusal to pay.
I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my Medical records. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.
In the event I do not pay charges when due, for these or any other services provided me, I agree to pay all cost of collection, including reasonable attorney fees.

I am aware that if laboratory (including pap smear, blood and urine testing, and biopsies) is obtained, there will be a separate charge from the pathology laboratory for this exam.

Patient Signature: _____Date: _____

Parent Signature if Minor: _____Date: _____

A photocopy of the authorization and assignment shall be considered as valid as the original.

Lakeside Doctors

Permission for Disclosure of Protected Health Information

I hereby acknowledge that I received a copy of this medical practice's *Notice of Privacy Practices*. I further acknowledge that I will be offered a copy of any amended *Notice of Privacy Practices* at each appointment.

I, _____, give my permission for Lakeside Doctors to give information to the people listed below about my medical care. This information may include lab results, medications being taken, appointments times, changes in appointments, x-ray results, doctor or nurse reports about me and any other information that this office has about me.
(Please DO NOT include other physicians or your employer in this list).

I understand it is my responsibility to keep this office updated on any changes to my personal information.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ _____
Signature of Patient (or Parent/Guardian if minor) Date

_____ _____
Witness Signature Date

OPPORTUNITY TO OBJECT

I, _____, do not want any information given to anyone but myself regarding my healthcare status or other patient information.

_____ _____
Signature of Patient (or Parent/Guardian if minor) Date

_____ _____
Witness Signature Date