OFFICE USE ONLY: DR ______________

WT ___________ HT _____________

BP____________ EDC____________

Lakeside Doctors
Gynecology & Obstetrics

Obstetrical Form

Patient History Questionnaire

1. Reason for this visit: ____

2. Referring Physician: ____ **3.** How did you hear about us? _____________________

4. Preferred phone number: ____________________________

5. Pharmacy, Address: ____ Pharmacy Phone: __________________

6. Primary Care Physician: ____________________________ Address: ______________________________ Phone: _______________

7. Partner's Name: ___________________________________ or ☐ NONE

8. Partner's Phone Number ( ) ____________________________ **9.** Partner's Age ______________

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/Menstrual 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. Date of pregnancy test:_____________ ☐ Blood ☐ Urine **7.** Were you on birth control when you became pregnant? _________

Pap Smear/ Mammogram

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: _________________

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

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. Marital Status: (circle one) Single Married Long Term Relationship Divorced Widowed

8. Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

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

10. Sexually Active? ☐ NO ☐ YES

11. Any new sexual partners in the last year? ☐ NO ☐ YES

12. Is sexual intercourse painful? ☐ NO ☐ YES

13. Current Birth Control Method: ________________________

14. Do You Drink Alcohol: ☐ NO ☐ YES How Many Drinks/Week? ________ Have you had any since your pregnancy test? ☐ NO ☐ YES

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

16. Do You Use Illicit Drugs: ☐ NO ☐ YES Type ____________________ Last Used ______________________

17. Number of Hours of Sleep Each Night: ______________hrs.

Past Obstetrical/Gynecological Surgeries

Check any that apply: or ☐ NONE

SURGERY	YEAR	SURGERY	YEAR
☐ Cesarean Section	_______________	☐ L Cyst(s) Removed Ovarian	______________
☐ D&C	_______________	☐ R Cyst(s) Removed Ovarian	______________
☐ Hysteroscopy	_______________	☐ L Ovary Removed	______________
☐ Infertility Surgery	_______________	☐ R Ovary Removed	______________
☐ Laparoscopy	_______________	☐ Vaginal or Bladder Repair	______________
☐ Myomectomy	_______________	☐ Other __________________________________	

Past Surgical History (Not OB/GYN)/ Hospitalizations

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

SURGERIES/ HOSPITALIZATIONS	YEAR
____	_______________
____	_______________
____	_______________

Other Symptoms ☐ NONE

Have you had recent?

☐ Breast Tenderness ☐ Cramping ☐ Fatigue ☐ Nausea

☐ Vaginal Bleeding ☐ Vomiting ☐ Weight Gain ☐ Weight Loss

☐ Other _____________________________________

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 ____________________________
☐ Diet Controlled ☐ Pill Controlled ☐ Insulin Controlled
☐ 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 ______________________
☐ 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)
☐ Other ___________________________________

Are you or will you be 35 years of age or older at delivery? ☐ NO ☐ YES

Have you traveled in the past 3 months? If so, where? ____

Have you had: ☐ Exposure to Tuberculosis ☐ Rash or viral illness since LMP ☐ Partner history of Genital Herpes

Have you or the baby's father or anyone in your families ever had any of the following:

☐ Down Syndrome? If yes, who? ____
☐ Other Chromosomal Abnormality? If yes, who? ____
☐ Neural Tube Defect (Spina Bifida, Anencephaly)? If yes, who? ____________________________________
☐ Hemophilia or Other Coagulation Abnormality? If yes, who? ______________________________________
☐ Muscular Dystrophy? If yes, who? ____
☐ Cystic Fibrosis? If yes, who? ____
☐ If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs Disease?
☐ Father Result ____
☐ Mother Result ____
☐ If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle Cell Trait?
☐ Father Result ____
☐ Mother Result ____
☐ If you or the baby's biological father are of Italian, Greek or Mediterranean background, have either of you been tested for B-thalessemia?
☐ Father Result ____
☐ Mother Result ____
☐ If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalessemia?
☐ Father Result ____
☐ Mother Result ____

1) Please select the answer that comes closest to how you have felt in the **last 7 days**:

a. I have been able to laugh and see the funny side of things:
   i. As much as I always could
   ii. Not quite so much now
   iii. Definitely not so much now
   iv. Not at all

b. I have looked forward with enjoyment to things:
   i. As much as I ever did
   ii. Rather less than I used to
   iii. Definitely less than I used to
   iv. Hardly at all

c. I have blamed myself unnecessarily when things went wrong:
   i. No, never
   ii. Not very often
   iii. Yes, some of the time
   iv. Yes, most of the time

d. I have been anxious or worried for no good reason:
   i. No, not at all
   ii. Hardly ever
   iii. Yes, sometimes
   iv. Yes, very often

e. I have felt scared or panicky for no very good reason
   i. No, not at all
   ii. No, not much
   iii. Yes, sometimes
   iv. Yes, quite a lot

f. Things have been getting on top of me:
   i. No, I have been coping as well as ever
   ii. No, most of the time I have coped quite well
   iii. Yes, sometimes I haven't been coping as well as usual
   iv. Yes, most of the time I haven't been able to cope at all

g. I have been so unhappy that I have had difficulty sleeping
   i. No, not at all
   ii. Not very often
   iii. Yes, sometimes
   iv. Yes, most of the time

h. I have felt sad or miserable
   i. No, Not at all
   ii. Not very often
   iii. Yes, sometimes
   iv. Yes, most of the time

i. I have been so unhappy that I have been crying
   i. No, never
   ii. Only occasionally
   iii. Yes, quite often
   iv. Yes, most of the time

j. The thought of harming myself has occurred to me
   i. Never
   ii. Hardly ever
   iii. Sometimes
   iv. Yes, quite often

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