MELINDA SPOONER, M.D. JENELLE WATTS, M.D.

Notice of Privacy Practices

PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS A REVISION AND BECAME EFFECTIVE OCTOBER 26, 2015

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) 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 your PHI. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer.

PROVIDER / CLINIC OBLIGATIONS

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. We are also required to abide by the terms of the notice currently in effect. In Texas we must inform you if we disclose your PHI electronically, and those electronic communications including PHI must be through a secure method of electronic media. We are required to notify you of a breach of your PHI as required by federal and state law.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, physical therapy, etc., may require that your relevant PHI be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes. We may not use or disclose most psychotherapy notes contained in your PHI. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Inspect and Copy. You have a right to inspect and obtain a copy of the PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and/or copy this PHI, you must submit a request in writing to our office. In Texas, we have up to 15 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefits program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to Request Restrictions. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. To request a restriction, you must make your request in writing to our office. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose PHI to your health plan with respect to healthcare for which you have paid in full out-of-pocket.

Right to Request Confidential Communications. You have the right to request confidential communication from us by alternative means or at an alternative location. To request confidential communications, you must make your request in writing to our office.

Right to Request an Amendment. If you feel your PHI that we have is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to our office. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of your PHI for purposes other than treatment, payment and health care operations, for which you provided written authorization for disclosure, or for disclosures made seven years prior to the date of the request. To request an accounting of disclosures, you must make your request in writing to our office.

Right to Get Notice of a Breach. We will notify you if your unsecured PHI has been breached.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any PHI we receive in the future. We will post a copy of our current notice at our office and on our website. The notice will contain the effective date on the first page of the notice.

COMPLAINTS

You may complain to us or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with our office, it must be made in writing and mailed to: Specialized Women's Healthcare, Attn: HIPAA Compliance Officer, 3804 West 15th St., Suite 140, Plano, TX 75075. **We will not retaliate against you for filing a complaint.**

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient (or Guarantor's) Name Printed	Patient (or Guarantor's) Signature	Date

HIPAA Consent Form

I understand that as part of my healthcare Jenelle Watts, MD and Melinda Spooner, MD originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The *Notice of Privacy Practices* provides specific information and complete description of how my protected health information (PHI) may be used and disclosed. I have been provided a copy of the office's *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Watts and Dr. Spooner reserve the right to change the *Notice of Privacy Practices.* I understand that I have the right to restrict the use and/or disclosure of my PHI for treatment, payment or healthcare operations and that Dr. Watts and Dr. Spooner are not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Dr. Watts or Dr. Spooner has already taken action in reliance of my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies applied to the entire PHI we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact Kimberly Smith, 469-326-1600, Ext 305.

NOTE: Dr. Watts and Dr. Spooner must obtain your written authorization to use your PHI for any purpose other than treatment, payment, or healthcare operations. If you want Dr. Watts or Dr. Spooner to have access to disclose your PHI to your spouse or any other person during your treatment, please list and sign below.

I agree to allow for Dr. Watts or Dr. Spooner to disclose my PHI (including date/time of appointments) to:

___ My Spouse_____ (printed name and phone number)

___ Other Member(s) _____

of my Family (printed name, relationship to patient, and phone number)

___ Other_____ _____

(printed name, relationship to patient, and phone number)

___ Myself only, no other family member ***This does not serve as an Authorization to Release Medical Record***

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed Dr. Watts' and Dr. Spooner's *Notice of Privacy Practices*.

_____ _____

Signature of Patient or Legal Representative Date

_____

Print Name of Patient or Legal Representative

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

Witness: _____ Date: _____

Specialized
WOMEN'S HEALTHCARE

Financial and Office Policies

This is an agreement between Specialized Women's Healthcare (SWHC), as creditor, and the Patient/Debtor named on this form. In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to SWHC.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days. Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Self-pay patients: All patients are required to pay their account in full at each appointment. Our office does not do payment plans.

Returned checks: There is a fee (currently $35.00) for any checks returned by the bank.

Contracted insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service.

Non-contracted insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. When we verify your insurance your company only gives us an estimate of what they may pay. They guarantee no payment before receipt of and it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Referrals/authorization: If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to do so may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The finance charge will be computed at the rate of one percent (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed 30 days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $0.50.

Past due account: If your account becomes past due, we will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau. There is a $25.00 collection fee added to all accounts sent for collection.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You must make your request in writing. There is a fee for a copy of your medical records as set for by the Texas Medical Records Act of 1981. The charge is $25.00 for the first 20 pages and $0.20 for every subsequent page.

Well Women vs. Problem Exam: A well woman exam is when a healthy patient is seen to screen for various illnesses or diseases; this is considered preventive medicine. If a patient comes in to discuss any suspected illness or disease, this is considered a problem-focused exam. We provide services for preventive medicine as well as problem-focused medicine. Some insurance plans cover all office visits no matter what the purpose. Other plans will only cover a visit if you have a problem and some will only cover preventive medicine. Our verification staff is dedicated to ensuring that your visit is covered by your insurance or advising you otherwise prior to your appointment. In some instances, we might not be able to obtain this information. It is always a good idea for you to check with your insurance carrier to verify your specific benefits so there are no unexpected financial surprises at the time of your visit. Payment for services is ultimately **your** responsibility.

Referrals: Occasionally our physicians will need to refer you to another specialist. Our physicians offer recommendations based on their experience with the specialist. The specialist they recommend may or may not be an in-network provider with your insurance carrier. You will need to contact your insurance carrier to find out if that physician is in-network. If they are not you can: 1) choose to see a physician in-network according to your carrier or 2) see the physician we recommend out-of-network. The latter may require you to pay more money out of your pocket. If you have an HMO or POS policy you may need a referral to see another physician. Please let us know if you do and we will be happy to take care of that for you if your plan allows. If your insurance is one that will not let us do referrals, you will need to call your Primary Care Physician (PCP) and ask them to do this for you. Please note that if your carrier requires you to choose a (PCP) you must have selected one before any office can complete referrals.

Laboratory Test: When you have a pap smear or any type of blood work done we will send the specimen to an outside lab.

We always try to send specimens to the lab your insurance company recommends. It is your responsibility to inform the nurse of what lab your insurance requires you use. Remember that since we do send all lab specimens to an outside lab we do not charge for the actual test; the lab will bill you separately if your insurance does not cover them.

Filing Claims: Please be sure that we have your current insurance information and inform us of any updates or changes. If we do not have current information this will delay payment and possibly cause you to have unexpected expenses. You will be asked to fill out a new information profile completely every year. These profiles expire one year after being signed. You will also be asked to sign in with your name, address, and current insurance information each time you are seen in our office.

Appointments: It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this we must require you to be on time for your appointments. If you must cancel an appointment, we ask that you give us 24 hours' notice whenever possible. Unfortunately, emergencies and deliveries do occur which occasionally causes delays in our schedule. We will try to keep you informed if these arise. Patients who are 15 or more minutes late will need to be rescheduled. If you miss three appointments without notifying us before the appointment time you will be dismissed from the practice.

Telephone Calls: We must screen all calls to the doctors during office hours while they are seeing patients. If you have an emergency, explain to the operator the type of emergency you have and a nurse will either pick up your call or call you back within the next few minutes. Calls deemed "non-emergent" will be handled by the clinical staff in the order received. If it is necessary to leave a message for the Doctor the call will be returned within 24–48 hours.

Prescription Refills: Prescription refill request will be handled within 24 hours of receipt during regular office hours. No routine prescriptions or narcotic pain medications will be handled after regular office hours or on the weekend.

Children: Children are very special to all of us and we are always happy to see the "little ones", but for their safety and the courtesy of other patients we must ask that you keep your children with you at **ALL** times while in our office.

Consent for Medical Treatment: I authorize Specialized Women's Healthcare to examine me and perform those procedures necessary for prenatal and/or family planning care and/or women's healthcare and/or general medical care. Procedures that may be performed include but are not limited to:

- Medical history and physical examination, including pelvic and breast examination
- Blood draws to screen for syphilis, anemia, rubella, diabetes, hepatitis, AIDS, HIV and other blood work determined to be necessary
- Urinalysis, urine pregnancy tests, urine culture and drug screens
- Gonorrhea,/Chlamydia culture and pap smear
- Other appropriate lab work
- Neonatal screening
- Ultrasound
- Necessary Immunizations

The nature of the procedures has been explained to me and no warranty or guarantee has been made to me as to the result.

Disclosure of Financial Interest/Ownership: Jenelle Watts, M.D. has interest/ownership in the following entities: A.) Surgery Center of Plano, located at 1620 Coit Rd., Building II, Plano, TX 75075; B.) Fertility Leaders of Texas, LLC, located at 4370 Medical Arts Drive, Suite 315, Flower Mound, TX 75028; and C.) Arbor Diagnostics, located at 1801 Royal Lane, Suite 805, Dallas, TX 75229.

TCPA Prior Express Consent Notice: The automatic dialing and prerecorded messages provisions of the Telephone Consumer Protection Act (TCPA) regulate parties who use automatic dialers or predictive dialers or prerecorded messages. Although, automated calls made by debt collectors to land lines are permissible under the TCPA as long as certain disclosures are provided, the regulations under the TCPA provide additional restrictions regarding the use of auto dialers and prerecorded messages to call a consumer's cellular telephone.

The TCPA prohibits a person from making "any call using any automatic telephone dialing system or an artificial or prerecorded voice" to any wireless telephone number unless the call is made for an emergency purpose ***** or the call is made with the prior express consent of the called party.

A 2008 Federal Communication Commission (FCC) Ruling clarified a consumer who gives prior express consent to the creditor (SWHC), similarly gives such consent to the debt collector (Meade & Associates) calling on behalf of the creditor (SWHC). If the underlying application, contact or other patient/customer demographics form provides a creditor (SWHC) with consent to contact a consumer's wireless number, this consent applies to the collector (Meade & Associates). There is no specific language that must be used in order to obtain prior express consent from a consumer to place an autodialed and prerecorded message call to a consumer's wireless number.

You agree, in order for us to provide services for you and your account and/or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read this disclosure and agree that the Creditor (SWHC) as well as their debt collector (Meade & Associates) may contact me/us as described above.

By signing below, I am acknowledging that I have read and understand this complete two page document of the office policies and my financial responsibility.

Patient (or Guarantor's) Name Printed:

_____

Signature:

_____

Date: _____

SPECIALIZED WOMEN'S HEALTHCARE, P.L.L.C.

PATIENT REGISTRATION

PATIENT'S FULL LEGAL NAME: _____

PATIENT'S ADDRESS: _____

CITY, STATE, ZIP CODE: _____

HOME/CELL PHONE: _____ **DRIVER'S LIC. #:** _____ **STATE:** ___

BIRTHDATE: _____ **SOCIAL SECURITY #:** _____ **EMAIL:** _____

PATIENT'S EMPLOYER: _____ **WORK PHONE:** _____

EMPLOYER'S ADDRESS: _____ **CITY, STATE, ZIP:** _____

MARITAL STATUS: □ Married □ Single □ Divorced □ Widowed **LANGUAGE:** □ English □ Spanish □ Other

SPOUSE'S NAME: _____ **REFERRED BY:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

EMERGENCY CONTACT PHONE #: _____

RACE: □ Asian □ White □ Black/African American □ Native Hawaiian □ Other Pacific Islander □ More than 1 race
□ American Indian / Alaska Native □ Unreported / Refused

ETHNICITY: □ Hispanic/Latino □ Not Hispanic/Latino □ Unreported / Refused

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(COMPLETE ONLY IF DIFFERENT FROM PATIENT)

PRIMARY POLICY HOLDER'S NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

HOME/CELL PHONE: _____ **DRIVER'S LIC. #:** _____ **STATE:** ___

SOCIAL SECURITY #: _____ **BIRTHDATE:** _____

EMPLOYER: _____ **WORK PHONE:** _____

EMPLOYER'S ADDRESS: _____

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS TO MAIL CLAIM: _____

MEMBER ID #: _____ **GROUP #:** _____ **COPAY AMOUNT:** _____

INSURED/POLICY HOLDER: _____ **MEMBER SERVICES #:** _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE OTHER _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS TO MAIL CLAIM: _____

MEMBER ID #: _____ **GROUP #:** _____ **COPAY AMOUNT:** _____

INSURED/POLICY HOLDER: _____ **MEMBER SERVICES #:** _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE OTHER _____

CONSENT FOR TREATMENT – RELEASE OF INFORMATION

( ) I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE PATIENT INDICATED ON THIS FORM. AUTHORIZATION IS HEREBY GRANTED TO RELEASE INFORMATION AS MAY BE NECESSARY TO PROCESS AND COMPLETE MY CLAIM

ASSIGNMENT OF INSURANCE BENEFITS

( ) I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE PAID DIRECTLY TO THE ATTENDING PHYSICIAN FOR SERVICES RENDERED.

_____ _____

DATE SIGNATURE

PATIENT INTAKE HISTORY			
Patient Name:	Birth Date: / /	SSN: - -	Date: / /
Name you would like to use:			
Primary Care Physician's Full Name:			
Why have you come to the office today?			
Is this a new problem:			
How did you hear about us: □ Physician Referral (Dr. _____) □ Family / Friend □ Insurance Company □ Medical Center of Plano □ TX Health Presbyterian Hospital Plano □ Magazine □ ZocDoc Website / App □ Internet Search (i.e. Google, Bing, Yahoo) □ Website for our Company □ Healthgrades Website □ Yelp Website / App			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	Physicians Notes
Last normal menstrual period (First Day): / /	
Age periods began:	
Length of periods (number of days bleeding):	
Number of days between periods:	
Any recent changes in periods?	
Are you currently sexually active?	
Have you ever had sex?	
Number of sexual partners (lifetime):	
Sexual partners are □ male □ female □ both	
Libido (Sex Drive): □ Normal □ Decreased □ Absent	
Present method of birth control:	
Have you ever used an intrauterine device (IUD) or birth control pills?	
If yes, for how long?	
Reproductive Procedures: Tubal Ligation: □ Yes □ No Hysterectomy: □ Yes □ No Partner Vasectomy: □ Yes □ No	
When was your last pap test?	
What was the result?	
Have you ever had an abnormal pap test?	
Do you do regular breast self-examinations?	
Last Mammogram: / /	

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature Birth (<37 weeks)		Live Births		Living children	

NO.	Birth Date	Weight at Birth	Baby's Sex	Weeks Pregnant	Type of Delivery (vaginal, cesarean)	Complications?
1.						
2.						
3.						
4.						

Physician's Notes on Obstetric History:
Length of Labor:
Place of Delivery:
Did you have an epidural?

PATIENT INTAKE HISTORY

Patient Name:	Birth Date: / /

FAMILY HISTORY

Mother: □ Living □ Deceased –Cause: Age:	Father: □ Living □ Deceased- Cause: Age:
Siblings: Number Living: Number Deceased: Cause(s)/Age(s):	
Children: Number Living: Number Deceased: Cause(s)/Age(s):	

Illness	**Yes**	**Which Relative(s) and Age of Onset**	**Physician's Notes**
Diabetes	□		
Stroke	□		
Heart Disease	□		
Blood Clots in Lungs or Legs	□		
High Blood Pressure	□		
High Cholesterol	□		
Osteoporosis (Weak Bones)	□		
Hepatitis	□		
HIV/AIDS	□		
Tuberculosis	□		
Birth Defects	□		
Drinking or Drug Problems	□		
Breast Cancer	□		
Colon Cancer	□		
Ovarian Cancer	□		
Uterine Cancer	□		
Mental Illness/ Depression	□		
Alzheimer's Disease	□		
Other	□		

SOCIAL HISTORY

	Yes	No	Physician's Notes
Ever Smoked? Current Smoking: Packs Per Day: Years:	□	□	
Alcohol: Drinks Per Day: Drinks Per Week:	□	□	
Recreational Drug Use	□	□	
Do You Get Regular Exercise: How Long and How Often?	□	□	
Dairy Product Intake/ Calcium Supplements: Quantity	□	□	
Have You Been Sexually Abused, Threatened, or Hurt By Anyone?	□	□	
How many hours of sleep do you usually get at night?			

PERSONAL PAST HISTORY OF ILLNESSES

Major Illnesses	Yes (Date)	No	Not Sure	Physician's Notes
Asthma				
Pneumonia/ Lung Disease				
Kidney Infections/ Stones				
Tuberculosis				

PATIENT INTAKE HISTORY	
Patient Name:	Birth Date: / /

PERSONAL PAST HISTORY OF ILLNESSES

Major Illnesses	Yes (Date)	No	Not Sure	Physician's Notes
Sexually Transmitted Disease				
HIV/ AIDS				
Heart Attack/ Problems				
Diabetes				
High Blood Pressure				
Stroke				
Rheumatic Fever				
Blood Clots in Lungs or Legs				
Eating Disorders				
Collagen Vascular Disease (Lupus)				
Chickenpox				
Cancer				
Reflux/ Hiatal Hernia/ Ulcers				
Depression/ Anxiety				
Anemia				
Blood Transfusions				
Seizures/ Convulsions/ Epilepsy				
Bowel Problems				
Glaucoma				
Cataracts				
Arthritis/ Joint Pain/ Back Problems				
Broken Bones				
Hepatitis/ Yellow Jaundice/ Liver Disease				
Thyroid Disease				
Gallbladder Disease				
Headaches				
Other				

OPERATIONS/ HOSPITALIZATIONS

Reason	Date	Hospital

PERSONAL PROFILE

Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual
Marital Status: □ Married □ Living With Partner □ Single □ Widowed □ Divorced
Number of Living Children:

PATIENT INTAKE HISTORY

Patient Name:	Birth Date: / /

IMMUNIZATIONS/ TEST

	Date		Date
Tetanus-Diphtheria Booster		Influenza Vaccine (Flu Shot)	
Hepatitis A Vaccine		Hepatitis B Vaccine	
Varicella Vaccine		Pneumococcal Vaccine	
Measles-Mumps-Rubella (MMR) Vaccine		Tuberculosis (TB) Skin Test: Result:	

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

PREFERRED PHARMACY **(include phone # and/or intersection of cross streets):**

ALLERGIES

□ **NO KNOWN ALLERGIES**

List Medication Allergies Below:	List Reaction		List Other Allergies Below (including Latex):	List Reaction

REVIEW OF SYSTEMS

(Please mark if any of the following symptoms apply to you now or since adulthood)

	Now	Past	Not Sure	Physician's Notes
1. Constitutional				
Weight Loss	□	□	□	
Weight Gain	□	□	□	
Fever	□	□	□	
Fatigue	□	□	□	
Change in Height	□	□	□	
2. Eyes				
Double Vision	□	□	□	
Spots Before Eyes	□	□	□	
Vision Changes	□	□	□	
Glasses/ Contacts	□	□	□	
3. Ear, Nose, and Throat				
Earaches	□	□	□	
Ringing in Ears	□	□	□	
Hearing Problems	□	□	□	
Sinus Problems	□	□	□	
Sore Throat	□	□	□	

	Now	Past	Not Sure
Mouth Sores	□	□	□
Dental Problems	□	□	□
4. Cardiovascular			
Painful Breathing	□	□	□
Chest Pain or Pressure	□	□	□
Difficulty Breathing on Exertion	□	□	□
Swelling of Legs	□	□	□
Rapid or Irregular Heartbeat	□	□	□
5. Respiratory			
Wheezing	□	□	□
Spitting up Blood	□	□	□
Shortness of Breath	□	□	□
Chronic Cough	□	□	□

PATIENT INTAKE HISTORY (CONTINUED)

Patient Name:	Birth Date: / /

REVIEW OF SYSTEMS

(Please mark if any of the following symptoms apply to you now or since adulthood)

	Now	Past	Not Sure	Physician's Notes		Now	Past	Not Sure
6. Gastrointestinal								
Frequent Diarrhea	□	□	□		**10. Breasts**			
Bloody Stool	□	□	□		Pain in Breast	□	□	□
Nausea/ Vomiting/ Indigestion	□	□	□		Nipple Discharge	□	□	□
Constipation	□	□	□		Lumps	□	□	□
Involuntary Loss of Gas or Stool	□	□	□		**11. Neurologic**			
7. Genitourinary					Dizziness	□	□	□
Blood in Urine	□	□	□		Seizures	□	□	□
Pain with Urination	□	□	□		Numbness	□	□	□
Strong Urgency to Urinate	□	□	□		Trouble Walking	□	□	□
Frequent Urination	□	□	□		Severe Memory Problems	□	□	□
Incomplete Emptying	□	□	□		Frequent or Severe Headaches	□	□	□
Involuntary/ Unintended Urine Loss	□	□	□		**12. Psychiatric**			
Urine Loss when Coughing or Lifting	□	□	□		Depression or Frequent Crying	□	□	□
Abnormal Bleeding	□	□	□		Severe Anxiety	□	□	□
Painful Periods	□	□	□		**13. Endocrine**			
Premenstrual Syndrome (PMS)	□	□	□		Hair Loss	□	□	□
Painful Intercourse	□	□	□		Heat/ Cold Intolerance	□	□	□
Fibroids	□	□	□		Abnormal Thirst	□	□	□
Infertility	□	□	□		Hot Flashes	□	□	□
DES Exposure	□	□	□		**14. Hematologic/ Lymphatic**			
Abnormal Vaginal Discharge	□	□	□		Frequent Bruises	□	□	□
8. Musculoskeletal					Cuts Do Not Stop Bleeding	□	□	□
Muscle Weakness	□	□	□		Enlarged Lymph Nodes (Glands)	□	□	□
Muscle or Joint Pain	□	□	□		**15. Allergic/ Immunologic**			
9. Skin					Medication Allergies	□	□	□
Rash	□	□	□		List Allergy and type of reaction			
Sores	□	□	□		Other Allergies, including Latex:	□	□	□
Dry Skin	□	□	□		List allergy and type of reaction			
Moles	□	□	□					

Form Completed By: □ Patient □ Office Nurse □ Physician □ Other	
Patient Signature:	Date:
Physician Signature:	Date:

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F):_____ **Today's Date(MM/DD/YY):**_____ **Health Care Provider:**_____

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.
If yes, indicate family relationship and age at diagnosis in the appropriate column.
Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	☒ Y ○ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	○ Y ○ N				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○ Y ○ N				
2 or more people in my family (can include me) with **breast cancer**, one at age 50 or younger	○ Y ○ N				
Ovarian (peritoneal/fallopian tube) cancer at any age	○ Y ○ N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	○ Y ○ N				
3 or more of these cancers on same side of the family at any age: **pancreatic, breast**, or **aggressive prostate*** *Gleason Score ≥7	○ Y ○ N				
Male **breast cancer** at any age	○ Y ○ N				
Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age	○ Y ○ N				
Pancreatic cancer or aggressive prostate cancer and one relative with **breast cancer at age 50 or younger**	○ Y ○ N				
20 or more **colon/rectal polyps** found in 1 person throughout their lifetime. Specify number_____	○ Y ○ N				
Colon/rectal or **Endometrial (uterine) cancer** before age 50	○ Y ○ N				
Personal history of **Endometrial (uterine) cancer** at any age‡	○ Y ○ N				
TWO individuals in my family (can include me): at least 1 with **colon/rectal *or* endometrial (uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	○ Y ○ N				
THREE OR MORE individuals in my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a colon/rectal or **endometrial (uterine) cancer**	○ Y ○ N				

‡ $PREMM_{(1,2,6)}$ **Score ≥ 5%**
* **Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).**

Have you or a family member had genetic testing for a **hereditary cancer syndrome**?	○ Y ○ N	If yes, Who?_____ What gene(s)?_____ What was the result? _____

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If YES, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update ☐ Other:_____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

MGMRHCPCFHQA 04/16

Patient Addressograph

OBSTETRIC MEDICAL HISTORY

Patient Name: _____

Date Form Completed: _____

* If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

1. ☐ Yes ☐ No Are you allergic to any medications?

If yes, please list: _____

2. Please mark any condition that you have or have had in the past:

☐ Cancer	☐ HIV/AIDS	☐ Diabetes
☐ Epilepsy	☐ Thyroid disorder	☐ Eating disorder
☐ Heart disease	☐ Headaches	☐ Depression
☐ High blood pressure	☐ Arthritis or lupus	☐ Asthma
☐ Kidney disease	☐ Frequent infections	☐ Anemia
☐ Hepatitis	☐ Bowel disease	☐ Herpes
☐ von Willebrand's disease or other bleeding disorders		☐ Sexually transmitted diseases
☐ Blood clotting disorder (eg, phlebitis)		☐ Recurrent urinary tract infections

Describe, if needed: _____

3. Please indicate any surgery that you have had: _____

4. Please describe any health problems or symptoms that you are having at this time: _____

5. ☐ Yes ☐ No Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. ☐ Yes ☐ No Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)?

If yes, please describe: _____

EXPOSURES AFFECTING HEALTH

1. ☐ Yes ☐ No Do you smoke cigarettes?

   If yes, how many packs per day? _____

2. ☐ Yes ☐ No Do you drink alcoholic beverages?

   If yes, how often? _____

   What type of drinks? _____

3. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: _____

4. Please list any illicit or recreational drugs used since your last period (eg, cocaine, marijuana):

5. ☐ Yes ☐ No Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)?

6. ☐ Yes ☐ No Are you ever exposed to chemicals or radiation (eg, X-rays)?

   If yes, please describe: _____

7. ☐ Yes ☐ No Are you on a restricted diet?

   If yes, please describe: _____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____

   ☐ Yes ☐ No Have you ever had an abnormal Pap test?

   If yes, when and how were you treated? _____

   What was the diagnosis? _____

2. ☐ Yes ☐ No Have you ever had gonorrhea ☐, chlamydia ☐, or pelvic inflammatory disease ☐ ?

   If yes, when, how, and where were you treated? _____

3. ☐ Yes ☐ No Have you ever had herpes?

   If yes, how often do you have outbreaks? _____

   ☐ Yes ☐ No Have you ever had syphilis?

   If yes, how, when, and where were you treated? _____

4. ☐ Yes ☐ No Have you ever used an IUD (intrauterine device) for contraception?

   If yes, please indicate when: _____

   ☐ Yes ☐ No Did you have any problem with the IUD?

   If yes, please describe: _____

5. ☐ Yes ☐ No Have you been treated for infertility?

   If yes, please describe when and treatment received: _____

6. ☐ Yes ☐ No Do you have any other concerns related to your past health history?

   If yes, please list: _____

FAMILY HISTORY & GENETIC SCREENING

1. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?

   If yes, please describe: _____

2. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?

   If yes, please describe: _____

3. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):

   _____

   _____

   _____

   How is this child/person related to you? _____

4. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn)?

   If yes, have either of you had genetic counseling? ☐ Yes ☐ No

   If yes, have either of you had chromosomal testing? ☐ Yes ☐ No

   Where and what were the results? _____

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

   ☐ Yes ☐ No Eastern Europe Jewish ancestry

   If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No

   If yes, have you had a Canavan screening test? ☐ Yes ☐ No

   Date _____ Result _____

   ☐ Yes ☐ No African American

   If yes, have you had sickle cell screening? ☐ Yes ☐ No

   Date _____ Result _____

   ☐ Yes ☐ No European Ancestry

   If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No

   ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry

   If yes, have you had screening for inherited forms of anemia such as thalassemia? ☐ Yes ☐ No

6. Please list any other concerns you have about birth defects or inherited disorders:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

7. ☐ Yes ☐ No Will you be 35 years or older at the time the baby is born?

8. ☐ Yes ☐ No Will the father be 50 years or older?

PSYCHOSOCIAL SCREENING*	
1. ☐ Yes ☐ No	Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐ No	Do you feel unsafe where you live?
3. ☐ Yes ☐ No	In the past 2 months, have you used any form of tobacco?
4. ☐ Yes ☐ No	In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐ No	In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐ No	Has anyone forced you to perform any sexual act that you did not want to do?
7.	On a 1–5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High
8.	How many times have you moved in the past 12 months? _____
9.	If you could change the timing of this pregnancy, would you want it ☐ Earlier ☐ Later ☐ Not at all ☐ No change

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____

Patient Signature

_____

Print Name

_____

Date