# OBGYN
Associates of Norman

www.obgynnorman.com

3441 24th Avenue NW, Suite 105
Norman, Oklahoma 73069
Office (405) 321-2929 || Fax (405)366-8701

## PATIENT INFORMATION

Name (Last , First) : ______________________ ______________________ MI __________

Address : ______________________________ City ____________ State _____ Zip ________

Home Phone: (_____)____________ Cell Phone : (_____)____________ Work Phone: (_____)__________

Primary Care Physician: ____________________________________________________

D.O.B.: ____ /____ /________ Sex: ☐ M ☐ F Marital Status: ________ SSN: ______ - _____ - ________

Occupation : __________________________ Employer : __________________________

Spouse Name: __________________________________ Phone: ( _____ ) ____________

Spouse Occupation /Employer : ____________________________________________

Emergency Contact : ____________________ Relationship : ____________________

**IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT COMPLETE THIS SECTION**

Name of responsible party : ______________________ Relationship : ______________

Address: ______________________________ Phone: (_____)____________

Employed by: ______________________________ Phone: (_____)____________

## MEDICAL INSURANCE INFORMATION

Primary Insurance Name & Payor ID # : ____________________________________________

Policy Number: ______________ Group Number : ______________ Office visit co-pay: ________

Policyholder : ______________________ Policyholder Date of Birth : ______________________

Secondary Insurance Name & Payor ID # : ______________________ Policy # : ____________

Policyholder : ______________________ Policyholder Date of Birth : ______________________

E-mail address (for Patient Portal) : ____________________________________________

Race: ☐ Asian ☐ Native American ☐ Black or African American ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin Primary Language: ______________

Local Pharmacy (Name & Address) : ____________________________________________

Mail Order Pharmacy (Name & Address): ____________________________________________

## AUTHORIZATION

*The above information is true and correct to the best of my knowledge.*

______________________________________________________________

*Signature of Patient (or Parent of Minor Patient)* *Date*

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# STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

## I. PATIENT INFORMATION

Name (Last , First) : ______________________ ______________________ D.O.B.: ____ /____ /________

Address : ________________________________ City ______________ State ______ Zip __________

## II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me the purpose of this authorization is to allow OB/GYN Associates of Norman to share my protected health information

## III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize OB/GYN Associates of Norman as set forth below to share my protected health information for reasons in addition to those already permitted by law

### A. Persons/Organizations Authorized to Receive My Information

Name (Last , First) : ______________________ ______________________ MI ________

Relationship : ______________________ Purpose : ______________________

Name (Last , First) : ______________________ ______________________ MI ________

Relationship : ______________________ Purpose : ______________________

### B. Information to be Shared

1. Check one or more boxes below

☐ Entire medical records (includes all records except psychotherapy notes)

| | | | |
|---|---|---|---|
| ☐ Psychotherapy Notes | ☐ Mental Health Record's | ☐ Pathology Report | ☐ Progress Notes |
| ☐ Consultation Report(s) | ☐ History and Physical | ☐ Physicians Orders | ☐ EKG Report(s) |
| ☐ Radiology Films | ☐ Laboratory Report(s) | ☐ Discharge Summary | ☐ Operation report(s) |
| ☐ Radiology Report(s) | ☐ Alcohol or Drug Abuse Records | | ☐ Other |

If other please explain : ________________________________________________

Covering Services Between : ______________________ and ______________________ (Insert either date(s) or "all")

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## IV. EXPIRATION AND REVOCATION

A. This expiration will expire (must choose one):

☐ 3 years after office encounter ☐ Other (insert date or event): ______________________

## V. ACKNOWLEDGMENTS AND SIGNATURES

### A. Acknowledgments

1. I understand his authorization is voluntary and will not affect my eligibility for benefits, treatments, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or healthcare provider, privacy regulations may no longer protect the information.

3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to address listed at the bottom of the form.

4. I understand **OB/GYN Associates of Norman** as a member of Oklahoma physical health exchange (OPHX) may utilize an electronic network to exchange my protected health information with other providers unless I choose not to participate.

5. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

### B. Signature

This document must be signed by the individual or the individuals legal representative.

______________________________________________ ______________________
*Signature (Parent or Legal Representative)* *Date*

______________________________________________ ______________________
*Printed Parent or Legal Representative Name* *Capacity of Legal Representative (if applicable)*

Physician/Clinic Address:

OB/GYN Associates of Norman
3441 24TH AVENUE NW, SUITE 105
NORMAN, OKLAHOMA 73069
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# PATIENT HEALTH HISTORY

DATE : ____ /____ /________

Name (Last , First) : ______________________ ______________________ MI ________

Age : ________ Marital Status : ____________ D.O.B. : ____ /____ /________ Race __________

## GYNECOLOGICAL HISTORY

When did your last period begin ? __________ Is your normal flow: ☐ Light ☐ Moderate ☐ Heavy

How old were you when you started having periods? __________ How long does your period last? ________

How many days apart are/were your normal periods? ______________________________

When and where was your last Pap smear? (Results if known) ____________________________

When and where was your last mammogram? (Results if known) ____________________________

When and where was your last colonoscopy? (Results if known) ____________________________

How many times have you been pregnant? _______________

Vaginal births : _______ C-sections : _______ How many living children currently? __________

Premature : ____ Miscarriages: ____ Abortions : ____ How many babies delivered full term? _______

What form of birth control do you use? ____________________________________________

Smoking history: ☐ Never ☐ Formerly ☐ Currently

REASON FOR TODAY'S VISIT: ________________________________________________

PLEASE LIST ANY PROBLEMS : ______________________________________________

## PAST MEDICAL HISTORY (Please mark all that apply)

☐ Allergies
☐ Anxiety
☐ Asthma
☐ Blood Transfusion
☐ Chlamydia
☐ Depression
☐ Diabetes Mellitus
☐ Genital Warts
☐ Gonorrhea
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High cholesterol
☐ High blood pressure
☐ Kidney Disease
☐ Liver Disease
☐ Migraine Headaches
☐ Sexually Transmitted Disease
☐ Thyroid Disease
☐ Cancer
☐ Other

If other please explain : ____________________________________________

## SURGICAL HISTORY (Please mark all that apply)

☐ Appendectomy
☐ Breast Surgery
☐ Cervical Surgery
☐ Cesarean Section
☐ Gallbladder
☐ Hysterectomy
☐ Ovarian Surgery
☐ Tonsillectomy
☐ Tubal Ligation
☐ Other

If other please explain : ____________________________________________

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## PATIENT HEALTH HISTORY

DATE : ____ /____ /_________

Name (Last , First) : ________________________________________ D.O.B. : ____ /____ /_________

**CURRENT MEDICATIONS (include over the counter, vitamins , supplements and inhalers)**

| MEDICATION: | DOSAGE: | DIRECTIONS: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**ALLERGIES** ☐ Please check here if you have no known drug allergies

| ALLERGIC TO: | REACTION |
|---|---|
| | |
| | |
| | |

**REVIEW OF SYSTEMS (Please indicate Yes or No and mark all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| Fatigue | ☐ Yes | ☐ No | Infertility | ☐ Yes | ☐ No |
| Fever | ☐ Yes | ☐ No | Pelvic Pain | ☐ Yes | ☐ No |
| Weight Loss | ☐ Yes | ☐ No | Problem with Menses | ☐ Yes | ☐ No |
| Skin Disease | ☐ Yes | ☐ No | Sexually Active | ☐ Yes | ☐ No |
| Seasonal Allergies | ☐ Yes | ☐ No | Vaginal discharge/itching | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Frequent Urination | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No | Painful Urination | ☐ Yes | ☐ No |
| Constipation | ☐ Yes | ☐ No | Urinary Incontinence | ☐ Yes | ☐ No |
| Diarrhea | ☐ Yes | ☐ No | Muscle pain | ☐ Yes | ☐ No |
| Nausea | ☐ Yes | ☐ No | Painful Joints | ☐ Yes | ☐ No |
| Vomiting | ☐ Yes | ☐ No | Dizziness | ☐ Yes | ☐ No |
| Contraception | ☐ Yes | ☐ No | Headache | ☐ Yes | ☐ No |
| Frequent Yeast Infections | ☐ Yes | ☐ No | Anxiety | ☐ Yes | ☐ No |
| Hot flashes | ☐ Yes | ☐ No | Depression | ☐ Yes | ☐ No |

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## PATIENT QUESTIONNAIRE

DATE : ____ /____ /________

Name (Last , First) : ______________________________ D.O.B.: ____ /____ /________

### FAMILY MEDICAL HISTORY

| | Father | Mother | Paternal Grandfather | Paternal Grandmother | Maternal Grandfather | Maternal Grandmother | Paternal Uncle | Paternal Aunt | Maternal Uncle | Maternal Aunt | Siblings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Breast Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Personal Information

**Patient Name: ___________________________________ Date of Birth: __________________Age: _______________**
**Today's Date:______________________ Health Care Provider:___________________________________**

**Instructions:** This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents or great grandchildren

## YOUR FAMILY'S Cancer History (Please be thorough and accurate)

| | CANCER | YOU (age) | PARENTS / SIBLINGS / CHILDREN | AGE | MOTHER'S SIDE | AGE | FATHER S SIDE | AGE |
|---|---|---|---|---|---|---|---|---|
| ☐ **Y** ☐ **N** | *EXAMPLE: BREAST CANCER* | | *Sister* | *41* | *Aunt* *Cousin* | *45* *61* | *Grandmother* | *53* |
| ☐ Y ☐ N | BREAST CANCER | | | | | | | |
| ☐ Y ☐ N | OVARIAN CANCER | | | | | | | |
| ☐ Y ☐ N | UTERINE/ENDOMETRIAL CANCER | | | | | | | |
| ☐ Y ☐ N | COLON/RECTAL CANCER | | | | | | | |
| ☐ Y ☐ N | OTHER CANCER(S) (SPECIFY): | | | | | | | |

☐ Y ☐ N Are you of Jewish descent?

**PATIENT SIGNATURE:**

## Testing Criteria (office use only)

***Hereditary Breast and Ovarian Cancer Syndrome***

- ☐ Breast cancer diagnosed under 50*
- ☐ Ovarian cancer at any age*
- ☐ Two primary breast cancers in the same person at any age*
- ☐ Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
- ☐ Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
- ☐ Male breast cancer
- ☐ Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer**
- ☐ Metastatic prostate cancer*
- ☐ PERSONAL HISTORY METASTATIC BREAST CANCER (patient only)
- ☐ Pancreatic cancer*

***Lynch Syndrome***

- ☐ colon/rectal cancer or endometrial cancer diagnosed at or under age 50*
- ☐ A personal history of two or more Lynch syndrome cancers one being colon or endometrial cancer***
- ☐ Two or more relatives with a Lynch syndrome cancer***, one before the age of 50 and one being colon or endometrial cancer
- ☐ Three or more relatives with a Lynch syndrome cancer*** at any age and one being colon or endometrial cancer

- ☐ A previously identified BRCA1 or BRCA2 mutation, or Lynch syndrome mutation in the family

* In self, first or second degree family members
**HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*
***Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

## Cancer Risk Assessment Review and Counseling (office use only)

Health Care Provider's Signature: _______________________________________________ Date: ____________________

Patient meets guidelines for genetic testing ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED Results Appt Date: ____________

**INFORMED REFUSAL:** My provider has recommended hereditary cancer testing (myRisk testing) based on my personal and/or family history of cancer. He/She has explained to me the benefits of the genetic test and the risks of not consenting to the test. Despite my provider's recommendation, I decline to consent to the genetic test. **PATIENT SIGNATURE:____________________**