

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 : _____ Phone : _____

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

**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")

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** 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
TELEPHONE (405) 321 -2929
FAX (405) 366-8701

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)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Herpes | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other | If other please explain : _____ | | |

SURGICAL HISTORY (Please mark all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Ovarian Surgery |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cervical Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Other | If other please explain : _____ | |



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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seasonal Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contraception	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Yeast Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hot flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pelvic Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problem with Menses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually Active	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vaginal discharge/itching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Painful Urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Painful Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/> Y <input type="checkbox"/> N <i>EXAMPLE: BREAST CANCER</i>		<i>Sister</i>	<i>41</i>	<i>Aunt Cousin</i>	<i>45 61</i>	<i>Grandmother</i>	<i>53</i>
<input type="checkbox"/> Y <input type="checkbox"/> N BREAST CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N OVARIAN CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N UTERINE/ENDOMETRIAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> 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:** _____