Sherry Niccoli MD, FACOG

Specialist in Obstetrics & Gynecology

234 N. Main Street, Gunnison, CO 81230
Phone: 970-641-2885 Fax: 970-641-2898

Thank you for making an appointment with our office. We are located in Gunnison on the corner of Main Street and Georgia, in the Main Place Building. The office is on the second floor.

Prior to your appointment, **please complete all the attached forms and bring them to your appointment. Failure to bring completed forms may result in rescheduling your appointment.**

Also, please remember to bring the following items along with you to your appointment:

- your insurance card(s)
- co-pay required by your insurance
- any medical records from your previous physician if applicable

As a courtesy to you, the Patient Accounts office will submit your insurance for you. Your insurance coverage is a contract between you and your insurance company and you are ultimately responsible for any bills incurred. Any co-payments, deductibles, or remaining balance due after insurance has processed your claim is your responsibility. Please contact our Patient Accounts office at 970-641-2885 if you are unable to pay your balance in full. We accept Visa and MasterCard for your convenience.

We look forward to seeing you at your upcoming appointment.

Sincerely,

Dr. Niccoli and staff

SHERRY L. NICCOLI, M.D., F.A.C.O.G.
Specialist in Obstetrics and Gynecology

Please Print and Complete All Information

Today's Date:_____

PATIENT'S PERSONAL INFORMATION

Single_____Married_____Separated_____Divorced_____Widow_____
Name:

_____
Last Name First Name Middle Initial

Mailing Address: _____
P.O. Box Number or Street Address

_____
City State Zip

Home Phone:_____ Work Phone: _____

Social Security Number:_____
Date of Birth: _____
Employer/Name of School: _____
Full Time: _____ Part Time: _____
Business Address:
_____
_____

Occupation/Student:_____
Spouse's Name:_____ Work Number: _____

PATIENT'S/RESPONSIBLE PARTY INFORMATION
(If person responsible for payment is patient write 'SAME' below)

Responsible Party: _____
Date of Birth:_____
Relationship to Patient: Self:_____ Spouse:_____ Other:_____
Social Security Number: _____
Responsible Party's Home Phone:_____
Address: _____
P.O. Box Number or Street Address

_____
City State Zip

Employer's Name:_____ Work Phone #:_____

Patient's Name: _____

PATIENT'S INSURANCE COMPANY'S NAME

Please present insurance cards to receptionist

PRIMARY Insurance Company's Name:
_____

Insurance Address: _____
City: _____ State: _____ Zip:_____
Name of Insured: _____
Date of Birth:_____
Relationship to Insured: Self_____ Spouse_____ Other_____
Insurance ID Number: _____
Group Number: _____

SECONDARY Yes_____ No_____
Insurance Company Name: _____
Insurance Address: _____
City: _____ State: _____ Zip:_____
Name of Insured: _____
Date of Birth:_____
Relationship to Insured: Self_____ Spouse_____ Other_____
Insurance ID Number: _____
Group Number: _____
Check if Approprate: Medigap Policy: _____ Retiree Coverage:_____

PATIENT'S REFERRAL INFORMATION
Referred by:
_____
_____

EMERGENCY CONTACT
Name:_____
Relationship to Patient:_____
Address: _____
City: _____ State: _____ Zip:_____
Phone Number:
(home)_____ (work)_____ (cell)_____

Patient's Name: _____

ASSIGNMENT OF BENEFITS* FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Sherry L. Niccoli, M.D. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Sherry L. Niccoli, M.D. to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall by as valid as the original.

Responsible Party:

_____ Relationship:_____
Please Print Name

_____ Date:_____
Signature

PRIVACY POLICY

SHERRY L. NICCOLI M.D., F.A.C.O.G
NOTICE OF PRIVACY PRACTICES
AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

1. OUR COMMITMENT TO YOU PRIVACY

OUR PRACTICE IS DEDICATED TO MAINTAINING THE PRIVACY OF YOUR INDIVIDUALLY INDENTIFIABLY HEALTH INFORMATION (IIHI). IN CONDUCTION OUR BUSINESS, WE WILL CREATE RECORDS REGARDING YOU AND THE TREATMENT AND SERVICES WE PROVIDE TO YOU. WE ARE REQUIRED BY LAW TO MAINTAIN THE CONFIDENTIALITY OF HEALTH INFORMATION IDENTIFIES YOU. WE ALSO ARE REQUIRED BY LAW TO PROVIDE YOU WITH THIS NOTICE OF OUR LEGAL DUTIES AND THE PRIVACY PRACTICES THAT WE MAINTAIN IN OUR PRACTICE CONCERNING YOU IHII. BY FEDERAL AND STATE LAW, WE MUST FOLLOW THE TERMS OF THE NOTICE OF PRIVACY PRACTICES THAT WE HAVE IN EFFECT AT THE TIME.

WE REALIZE THAT THESE LAWS ARE COMPLICATED, BUT WE MUST PROVIDE YOU WITH THE FOLLOWING IMPORTANT INFORMATION:

- HOW WE MAY USE AND DISCLOSE YOUR IIHI
- YOUR PRIVACY RIGHTS IN YOUR IIHI
- OUR OBLIGATIONS CONCERNING THE USE AND DISCLOSURE OF YOUR IIHI

THE TERMS OF THIS NOTICE APPLY TO ALL RECORDS CONTAINING YOU IIHI THAT ARE CREATED OR RETAINED BY OUR PRACTICE WE RESERVE THE RIGHT TO REVISE OR AMEND THIS NOTICE OF PRIVACY PRACTICES. ANY REVISION OR AMENDMENT TO THIS NOTICE WILL BE EFFECTIVE FOR ALL OF YOUR RECORDS THAT OUR PRACTICE HAS CREATED OR MAINTAINED IN THE PAST, AND FOR ANY OF YOUR RECORDS THAT MAY CREATE OR MAINTAIN IN THE FUTURE. OUR PRACTICE WILL POST A COPY OF OUR CURRENT NOTICE IN OUR OFFICE IN A VISIBLE LOCATION AT ALL TIMES, AND MAY REQUEST A COPY OF OUR MOST CURRENT NOTICE AT ANY TIME.

2. **IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: THE OFFICE OF SHERRY NICCOLI 970-641-2885**

3. **WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS**

- **TREATMENT.** OUR PRACTICE MAY USE YOUR IIHI TO TREAT YOU. FOR EXAMPLE WE MAY ASK YOU TO HAVE LABORATORY TESTS (SUCH AS BLOOD OR URINE TESTS), AND WE MAY USE THE RESULTS TO HELP US REACH A DIAGNOSIS. WE MIGHT USE YOUR IIHI TO WRITE A PRESCRIPTION FOR YOU, OR WE MIGHT DISCLOSE YOUR IIHI TO A PHARMACY WHEN WE ORDER A PRESCRIPTION FOR YOU. ALL OF THE PEOPLE THAT WORK IN OUR PRACTICE MAY USE OR DISCLOSE YOUR IIHI TO OTHERS IN ORDERTO TREAT YOU OR TO ASSIST OTHERS IN YOUR TREATMENT. ADDITIONALLY WE MAY DISCLOSE YOUR IIHI TO OTHERS THAT MAY ASSIST IN YOUR CASE, SUCH AS A SPOUSE, CHILDREN OR PARENTS. FINALLY WE MAY ALSO DISCLOSE YOUR IIHI TO OTHER HEALTH CARE PROVIDERS FOR PURPOSES RELATED TO YOUR TREATMENT.
- **PAYMENT.** OUR PRACTICEMAY USE AND DISCLOSE YOUR IIHI IN ORDER TO BIL AND COLLECT FOR THE SERVICES AND ITEMS YOU MIGHT RECEIVE FROM US. FOR EXAMPLE, WE MAY CONTACT YOU INSURER TO CERTIFY THAT YOU ARE ELIGILBLE FOR BENEFITS (AND FOR WHAT RANGE OF BENEFITS), AND WE MAY PROVIDE YOUR INSURER WITH DETAILS REGARDING YOUR TREATMENT TO DETERMINE IF YOUR INSURER WILL COVER, OR PAY FOR, YOUR TREATMENT. WE ALSO MAY USE AND DISCLOSE YOU IIHI TO OBTAIN PAYMENT FROM THIRD PARTIES THAT MAY BE RESPONSIBLE FOR THOSE COSTS, SUCH AS FAMILY MEMBERS. ALSO, WE MAY USE YOU IIHI TO BILL YOU DIRECTLY FOR SERVICES AND ITEMS. WE MAY DISCLOSE YOU IIHI TO EITHER HEALTHCARE PROVIDERS OR ENTITIES TO ASSIST IN THEIR BILLING AND COLLECTION EFFORTS.
- **HEALTH CARE OPERATIONS.** OUR PRACTICE MAY USE AND DISCLOE YOUR IIHI TO OPERATE OUR BUSINESS. AS EXAMPLES OF THE WAYS IN WHICHWE MAY USE AND

DISCLOSE YOUR INFORMATION FOR OUR OPERATIONS, OUR PRACTICE MAY USE YOUR IIHI TO EVALUATE THE QUALITY OF CARE YOU RECEIVED FROM US, OR TO CONDUCT COST MANAGEMENT AND BUSINESS PLANNING ACTIVITIES FOR OUR PRACTICE. WE MAY DISCLOSE YOU IIHI TO OTHER HEALTH CARE PROVIDERS AND ENTITITIES TO ASSIST IN THEIR HEALTH CARE OPERATIONS.

- ❖ **APPOINTMENT REMINDERS.** OUR PRACTICE MAY USE AND DISCLOSE YOUR IIHI TO CONTACT YOU AND REMIND YOU OF AN APPOINTMENT.
- ❖ **TREATMENT OPTIONS.** OUR PRACTICE MAY USE AND DISCLOSE YOUR IIHI TO INFORM YOU OF POTENTIAL TREATMENT OPTIONS.
- ❖ **DISCLOSURES REQUIRED BY LAW.** OUR PRACTICE WILL USE AND DISCLOSE YOUR IIHI WHEN WE ARE REQUIRED TO DO SO BY FEDERAL, STATE OR LOCAL LAW.

4. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES.

- ❖ **PUBLIC HEALTH RISKS.** OUR PRACTICE MAY DISCLOSE YOUR IIHI TO PUBLIC AUTHORITIES THAT ARE AUTHORIZED BY LAW TO COLLECT INFORMATION FOR THE PURPOSE OF:
  - MAINTAINING VITAL RECORDS, SUCH AS BIRTHS AND DEATHS.
  - REPORTING CHILD ABUSE OR NEGLECT.
  - PREVENTING OR CONTROLLING DISEASE, INJUSRY OR DISABILITY.
  - NOTIFYING A PERSON REGARDING POTENTIAL EXPOSURE TO COMMUNICABLE DISEASE.
  - NOTIFYING A PERSON REGARDING A POTENTIAL RISK FOR SPREADING OR CONTRACTING A DISEASE OR CONDITION.
  - REPORTING REACTIONS TO DRUGS OR PROBLEMS WITH PRODUCTS OR DEVICES.
  - NOTIFYING APPROPRATE GOVERNMENT AGENCIESAND AUTHORITIES REGARDING THE POTENTIAL ABUSE OR NEGLECT OF AN ADULT PATIENT (INCLUDING DOMESTIC VIOLENCE); HOWEVER, WE WILL ONLY DISCLOSE THIS INFORMATION IF THE PATIENT AGREES OR WE ARE REQUIRED OR AUTHORIZED BY STATE LAW TO DISCLOSE THIS INFORMATION.
  - NOTIFYING YOUR EMPLOYER UNDER LIMITED CIRCUMSTANCES RELATED PRIMARILY TO WORKPLACE INJURY OR ILLNESS OR MEDICAL SURVEILLANCE.

- ❖ **HEALTH OVERSIGHT ACTIVITIES.** OUR PRACTICE MAY DISCLOSE YOUR IIHI TO HEALTH OVERSIGHT AGENCY FOR ACTIVITIES AUTHORIZED BY LAW. OVERSIGHT ACTIVITIES CAN INCLUDE, FOR EXAMPLE, INVESTIGATIONS, INSPECTIONS, AUDITS, SURVEYS, LICENSURE AND DISCIPLINARY ACTIONS; CIVIL, ADMINISTRATIVE, AND CRIMINAL PROCEDURES OR ACTIONS; OR OTHER ACTIVITIES NECESSARY FOR THE GOVERNMENT TO MONITOR PROGRAMS, COMPLIANCE WTTH CIVIL RIGHTS LAWS AND THE HEALTH CARE SYSTEM IN GENERAL.
- ❖ **LAWSUITS AND SIMILAR PROCEEDINGS.** OUR PRACTICE MAY USE AND DISCLOSE YOUR IIHI IN RESPONSE TO A COURT OR ADMINISTATIVE ORDER, IF YOU ARE INVOLVED IN A LAWSUIT OR SIMILAR PROCEDING. WE ALSO MAY DISCLOSE YOUR IIHI IN RESPONSE TO A DISCOVERY REQUEST, SUBPOENA, OR OTHER LAWFUL PROCESS BY ANOTHER PARTY INVOLVED IN THE DISPUTE, BUT ONLY IF WE HAVE MADE AND EFFORT TO INFORM YOU OF THE REQUEST OR TO OBTAIN AN ORDER PROTECTING THE INFORMATION THE PARTY HAS REQUESTED.

5. **YOUR RIGHTS REGARDING YOUR IIHI**
YOU HAVE THE FOLLOWING RIGHTS REGARDING THE IIHI THAT WE MAINTAIN ABOUT YOUR.

- ❖ **CONFIDENTIAL COMMUNICATIONS.** YOU HAVE THE RIGHT TO REQUEST THAT OUR PRACTICE COMMUNICATE WITH YOU ABOUT YOUR HEALTH AND RELATED ISSUES IN A PARTICULAR MANNER OR AT A CERTAIN LOCATION. FOR INSTANCE, YOU MAY ASK THAT WE CONTACT YOU AT HOME RATHER THAN AT WORK. IN ORDER TO REQUEST A TYPE OF CONFIDENTIAL COMMUNICATION, YOU MUST MAKE A WRITTEN REQUEST TO OUR OFFICE SPECIFYING THE REQUESTED METHOD OF CONTACT, OR THE LOCATION WHERE YOU WISH TO BE CONTACTED. OUR PRACTICE WILL ACCOMMODATE **REASONABLE** REQUESTS. YOU DO NOT NEED TO GIVE REASON FOR YOUR REQUEST.
- ❖ **REQUESTING RESTRICTIONS.** YOU HAVE THE RIGHT TO REQUEST A RESTRICTION IN OUR USE OR DISCLOSURE OF YOUR IIHI FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. ADDITIONALLY, YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT OUR DISCLOSURES OF YOUR IIHI TO ONLY CERTAIN INDIVIDUALS INVOLVED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE. SUCH AS FAMILY MEMBERS OR FRIENDS. **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST; HOWEVER**, IF WE DO AGREE, WE ARE BOUND BY OUR AGREEMENT EXCEPT OTHERWISE REQUIRED BY LAW, IN EMERGENCIES, OR WHEN

THE INFORMATION IS NECESSARY TO TREAT YOU. IN ORDER TO REQUEST A RESTRICTION IN OUR USE OR DISCLOSURE OF YOU IIHI, YOU MUST MAKE YOUR REQUEST IN WRITING TO OUR OFFICE. YOUR REQUEST MUST DESCRIBE IN A CLEAR AND CONCISE FASHION:

- THE INFORMATION YOU WISH RESTRICTED
- WHETHER YOU ARE REQUESTING TO LIMIT OUR PRACTICE'S USE, DISCLOSURE, OR BOTH
- TO WHOM YOU WANT THE LIMITS TO APPLY

❖ **INSPECTION AND COPIES.** YOU HAVE THE RIGHT TO INSPECT AND OBTAIN A COPY O FTHE IIHI THAT MAY BE USED TO MAKE DECISIONS ABOUT YOU, INCLUDING PATIENT MEDICAL RECORDS AND BILLING RECORDS, BUT NOT INCLUDING PSHYCOTHERAPY NOTES. YOU MUST SUBMIT YOUR REQUEST IN WRITING TO OUR OFFICE IN ORDER TO INSPECT AND/OR OBTAIN A COPY OF YOUR IIHI. OUR PRACTICE MAY CHARGE A FEE FOR THE COSTS OF COPYING, MAILING, LABOR AND SUPPLIES ASSOCIATED WITH YOUR REQUEST. OUR PRACTICE MY DENY YOUR REQUEST TO INSPECT AND/OR COPY IN CERTAIN LIMITED CIRCUMSTANCES; HOWEVER, YOU MAY REQUEST A REVIEW OF DENIAL. ANOTHER LICENSED HEALTH CARE PROFESSIONAL CHOSEN BY US WILL CONDUCT REVIEWS.

❖ **AMENDMENT.** YOU MAY ASK TO AMEND YOUR HEALTH INFORMATION IF YOU BELIEVE IT IS INCORRECT OR INCOMPLETE, AND YOU MAY REQUEST AN AMENDMENT FOR AS LONG AS THE INFORMATION IS KEPT BY OR FOR OUR PRACTICE. TO REQUEST AN AMMENDMENT, YOUR REQUEST MUST BE MADE IN WRITING AND SUBMITTED TO OUR OFFICE. YOU MUST PROVIDE US WITH A REASON THAT SUPPORTS YORU REQUEST FOR AMMENDMENT. OUR PRACTICE WILL DENY YOUR REQUEST IF YOU FAIL TO SUBMIT YOUR REQUEST (AND THE REASON SUPPORTING YOUR REQUEST) IN WRITING. ALSO, WE MAY DENY YOUR REQUEST IF YOU ASK US TO AMEND INFORMATION THAT IS IN OUR OPINION: ACCURATE AND COMPLETE, NOT PART OF THE IIHI KEPT BY OR FOR OUR PRACTICE, NOT PART OF THE IIHI WHICH YOU WOULD BE PERMITTED TO INSPECT AND COPY, OR NOT CREATED BY OUR OFFICE, UNLESS THE INDIVIDUAL OR ENTITY THAT CREATED THE INFORMATION IS NOT AVAILABLE TO AMEND THE INFORMATION.

❖ **RIGHT TO A PAPER COPY OF THIS NOTICE.** YOU ARE ENTITILED TO RECEIVE A PAPER COPY OF OUR NOTICE OF PRIVACY PRACTICES. YOU MAY ASK US TO GIVE YOU A COPY OF THIS NOTICE AT ANY TIME. TO OBTAIN A PAPER COPY OF THIS NOTICE, CONTACT OUR BUSINESS OFFICE.

❖ **RIGHT TO FILE A COMPLAINT.** IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH OUR PRACTICE OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. TO FILE A COMPLAINT WITH OUR PRACTICE, CONTACT OUR OFFICE MANAGER AT 970-641-2885. ALL COMPLAINTS MUST BE SUBMITTED IN WRITING. **YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.**

❖ **RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES.** OUR PRACTICE WILL OBTAIN YOUR WRITTEN AUTHORIZATION FOR USES AND DISCLOSURES THAT ARE NOT IDENTIFIED BY THIS NOTICE OR PERMITTED BY APPLICABLE LASW. ANY AUTHORIZATION YOU PROVIDE TO US REGARDING THE USE AND DISCLOSURE OF YOUR IIHI MAY BE REVOKED A TANY TIME **IN WRITING.** AFTER YOU REVOKE YOUR AUTHORIZATION, WE WILL NO LONGER USE OR DISCLOSE YOUR IIHI FO RTHE REASONS DESCRIBED IN THE AUTHORIZATION. PLEASE NOT WE ARE REQUIRED TO RETAIN RECORDS OF YOU CARE.

AGAIN, IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY POLICIES, PLEASE CONTACT **THE OFFICE OF DR. SHERRY NICCOLI AT 970-641-2885**.

Sherry Niccoli, M.D., F.A.C.O.G.
234 North Main Street, Ste 2C
Gunnison, Co 81230

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the Office
Patients Name

of Dr, Sherry Niccoli's Notice of Privacy Practices. I also acknowledge that I have read and understand the Notice of Privacy Practices.

_____ _____
Signature of Patient/Guardian Date

FOR OFFICE USE ONLY
__ NEW PATIENT
__ ESTABLISHED PATIENT
__ CONSULTATION
__ REPORT SENT __/__/__

PATIENT INTAKE HISTORY

Patient Name: _____

Birth date:_____

Address:_____
City:_____ State:_____Zip:_____

Email Address: _____

Home Phone:_____Work Phone:_____

Employer:_____Insurance:_____

Name you would like us to use:_____

Name of Spouse/Partner:_____

Emergency Contact:_____
Relationship:_____
Home Phone: _____Work Phone:_____

Referred by:_____

Why have your come to the office today:_____

If you are here for an annual examination is this a:
_____ Primary Care Visit or _____ Gynecologic only

Is this a new problem?_____

Please describe your problem, including where it is, how severe, and how long it's lasted
_____
_____
_____

PATIENT INTAKE HISTORY (Continued) DATE:_____

PATIENT NAME: _____ BIRTHDATE: _____

GYNECOLOGIC HISTORY

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

LAST NORMAL PERIOD (FIRST DAY): ____/____/____

AGE PERIODS BEGAN:_____

LENGTH OF PERIODS (NUMBER OF DAYS OF 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: ____MEN ____WOMEN ___BOTH

PRESENT METHOD OF BIRTH CONTROL:_____

HAVE YOUR EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROLL PILLS:_____

IF YES, HOW LONG:_____

WHEN WAS YOUR LAST PAP TEST:_____

WHAT WAS THE RESULT:_____

HAVE YOU EVER HAD AN ABNORMAL PAP TEST:_____

DO YOU DO REGULAR BREAST EXAMINATIONS:_____

PHYSICIAN'S NOTES

OBSTETRIC HISTORY

NUMBER OF:

PREGNANCIES:_____ ABORTIONS: _____ MISCARRIAGES: _____

PREMATURE BIRTHS (<37 WEEKS): _____ LIVE BIRTHS: _____ LIVING CHILDREN: _____

NO.	BIRTHDATE	BIRTH WEIGHT	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESARIAN, ETC.)	COMPLICATIONS
1.						
2.						
3.						
4.						

PHYSICIANS NOTES ON OBSTETRIC HISTORY:
_____
_____
_____

PATIENT INTAKE HISTORY (Continued)	DATE:_____
PATIENT NAME: _____	BIRTHDATE: _____

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: _____LIVING _____DECEASED – CAUSE:_____ AGE:_____

FATHER: _____LIVING _____DECEASED – CAUSE:_____ AGE:_____

SIBLINGS: NUMBER LIVING:_____ NUMBER DESCEASED_____ CAUSES/AGE(S): _____

CHILDREN: NUMBER LIVING:_____ NUMBER DESCEASED_____ CAUSES/AGE(S): _____

ILLNESS	YES	WHICH RELATIVE AND AGE OF ONSET	PHYSICIANS 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	PHYSICIANS NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:			
ALCOHOL: DRINKS PER DAY: PER WEEK:			
RECREATIONAL DRUG USE:			
SEAT BELT USE:			
REGULAR EXERCISE: HOW LONG & OFTEN?			
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QTY:			
HEALTH HAZARDS AT HOME OR WORK?			
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE?			

PATIENT INTAKE HISTORY (Continued)	DATE:_____
PATIENT NAME: _____	BIRTHDATE: _____

PERSONAL PROFILE

SEXUAL ORIENTATION: _____ HETEROSEXUAL _____ HOMOSEXUAL _____ BISEXUAL

MARITAL STATUS: _____ MARRIED _____LIVING W/ PARTNER _____WIDOWED _____ DIVORCED

NUMBER OF LIVING CHILDREN:_____

NUMBER OF PEOPLE IN HOUSEHOLD: _____

SCHOOL COMPLETED: _____ HIGH SCHOOL _____ SOME COLLEGE/AA DEGREE _____COLLEGE
_____ GRADUATE DEGREE _____ OTHER

CURRENT OR MOST RECENT JOB:_____

TRAVEL OUTSIDE THE U.S.?_____

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
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				
ATRHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/ YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

PATIENT INTAKE HISTORY (Continued)	DATE:_____
PATIENT NAME: _____	BIRTHDATE: _____

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

REASON	DATE	REASON	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_____	

PHYSICIAN'S NOTES:

PATIENT INTAKE HISTORY (Continued)	DATE:_____
PATIENT NAME: _____	BIRTHDATE: _____

REVIEW OF SYSTEMS

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

1. CONSTITUTIONAL	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
WEIGHT LOSS				
WEIGHT GAIN				
FEVER				
FATIGUE				
CHANGE IN HEIGHT				
2. EYES	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
DOUBLE VISION				
SPOTS BEFORE EYES				
VISION CHANGES				
GLASSES/CONTACTS				
3. EAR, NOSE AND THROAT	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
EARACHES				
RINGING IN EARS				
HEARING PROBLEMS				
SINUS PROBLEMS				
SORE THROAT				
MOUTH SORES				
DENTAL PROBLEMS				
4. CARDIOVASCULAR	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
PAINFUL BREATHING				
CHEST PAIN OR PRESSURE				
DIFFICULTY BREATHING ON EXERTION				
SWELLING OF LEGS				
RAPID OR IRREGULAR HEARTBEAT				
5. RESPIRATORY	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
WHEEZING				
SPITTING UP BLOOD				
SHORTNESS OF BREATH				
CHRONIC COUGH				
6. GASTROINTESTINAL	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
FREQUENT DIARRHEA				
BLOODY STOOL				
NAUSEA/VOMINTING/INDIGESTION				
CONSTIPATION				
INVOLUNTARY LOSS OF GAS OR STOOL				

PATIENT INTAKE HISTORY (Continued) DATE:_____

PATIENT NAME: _____ BIRTHDATE: _____

REVIEW OF SYSTEMS (Continued)

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

7. GENITOURINARY	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
BLOOD IN UNINE				
PAIN WITH URINATION				
STRONG URGENCY TO URINATE				
FREQUENT URINATION				
INCOMPLETE EMPTYING				
INVOLUNTARY/UNINTENDED URINE LOSS				
URINE LOSS WHEN COUGHING OR LIFTING				
ABNORMAL BLEEDING				
PAINFUL PERIODS				
PREMENSTRUAL SYNDROME (PMS)				
PAINFUL INTERCOURSE				
FIBROIDS				
INFERTILITY				
DES EXPOSURE				
ABNORMAL VAGINAL DISCHARGE				
8. MUSCULOSKELETAL	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
MUSCLE WEAKNESS				
MUSCLE OR JOINT PAIN				
9. SKIN	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
RASH				
SORES				
DRY SKIN				
MOLES				
10. BREASTS	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
PAIN IN BREAST				
NIPPLE DISCHARGE				
LUMPS				
11. NEUROLOGIC	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
DIZZINESS				
SEIZURES				
NUMBNESS				
TROUBLE WALKING				
SEVERE MEMORY PROBLEMS				
FREQUENT OR SEVERE HEADACHES				

PATIENT INTAKE HISTORY (Continued)	DATE:_____
PATIENT NAME: _____	BIRTHDATE: _____

REVIEW OF SYSTEMS (Continued)
Please check (x) if any of the following symptoms apply to you now or since adulthood

12. PSYCHIATRIC	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
DEPRESSION OR FREQUENT CRYING				
SEVERE ANXIETY				
13. ENDOCRINE	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
HAIR LOSS				
HEAT/COLD INTOLERANCE				
ABNORMAL THIRST				
HOT FLASHES				
14. HEMATOLOGIC/LYMPHATIC	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
FREQUENT BRUISING				
CUTS DO NOT STOP BLEEDING				
ENLARGED LYMPH NODES (GLANDS)				
15. ALLERGIC/IMMUNOLOGIC	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
MEDICATION ALLERGIES				
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
OTHER ALLERGIES				
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				

FORM COMPLETED BY: _____PATIENT _____ OFFICE NURSE _____ PHYSICIAN _____ OTHER

SIGNATURE OF PATIENT:	
DATE REVIEWED BY PHYSICIAN WITH PATIENT: ____/___/_____	PHYSICIAN SIGNATURE:

ANNUAL REVIEW OF HISTORY

DATE REVIEWED BY PHYSICIAN WITH PATIENT: ____/___/_____	PHYSICIAN SIGNATURE:
DATE REVIEWED BY PHYSICIAN WITH PATIENT: ____/___/_____	PHYSICIAN SIGNATURE:
DATE REVIEWED BY PHYSICIAN WITH PATIENT: ____/___/_____	PHYSICIAN SIGNATURE: