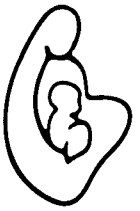
WELCOME TO OUR OFFICE

Donna Chester, M.D.
Dolly LeFever, ANP, CNM



Caring for Women
A PROFESSIONAL CORPORATION
SPECIALIZING IN WOMEN'S HEALTH CARE
2841 DeBarr, Suite 37, Anchorage, Alaska 99508
Telephone (907) 279-2229 • FAX (907) 279-3817

Date: _____

Acct #: _____

Thank you for choosing our office.

In order to serve you properly, we will need the following information. All information will be strictly confidential.

Patient Name	Hm. Ph.	Birthdate / /	Marital Status
	Cell Ph.	Soc. Sec. #	
Mailing Address	CITY	STATE	Zip Code
Residential Address	CITY	STATE	Zip Code
Name & Address of Employer Occupation		Wk. Ph.	
Spouse / Parent Name (Circle One)		DOB / /	
Employer Name & Address Occupation		Soc. Sec. # Bus. Ph.	
Primary Insurance Carrier		**Phone #**	
Address		Preferred Hospital	
Policy Holder	ID #	Group #	
Secondary Insurance Carrier		**Phone #**	
Address			
Policy Holder	ID #	Group #	
Medicaid #			
Emergency Contact Name:		Phone #	
Relationship to patient			

Referral Source? ❑ Patient Name_____ ❑ Internet ❑Yellow Pages

❑Mailing ❑ Physician Referral _____

When we need to call you, what number do you prefer that we use?_____

* I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, Guardian Signature _____ Date_____

CARING FOR WOMEN
DONNA L. CHESTER, MD, FACOG

WELCOME TO OUR PRACTICE

04/15/2015

Here at *Caring For Women, PC,* we specialize in gynecological care. Due to the nature and type of specialty practice we have, unavoidable delays or rescheduling of your visit may occur due to surgical or on call emergencies. Please be assured that you will be given the same courtesy and treatment if you require emergency treatment during office hours. We will reschedule your appointment if you are unable to wait.

AFTER HOURS CALL: If you have a medical situation that cannot wait until the next business day, call our regular phone number and you will get our answering service. They will call the "on call" doctor. **If you have not received a return call within an hour, call again.** Sometimes errors are made in phone numbers or in paging. We want you to be helped quickly and efficiently. So please call again and let the answering service know it has been over and hour and you have not received a call. If your situation is a true emergency, please go straight to the emergency room, if appropriate.

ON CALL DOCTORS: Dr. Donna Chester, Dr. Linda Wrigley, Dr. Rhene Merkouris, and Dr. Mark Richey all cover for each other on weekdays and holidays. One of these doctors will be available at all times. In rare instances, when the physician on call is unavailable and the other physicians are out of town, another doctor in the community may provide care as the call physician sees fit. There will always be a physician available to answer your questions or help with emergencies if the need arises. **On call physicians do not refill prescriptions.**

PRESCRIPTIONS: You may request prescription refills 48 hours in advance by calling our office at 279-2229 during regular office hours. Please call *at least* two days before your medicine runs out. Be prepared to give the name of your medication, the dosage you take and the pharmacy to which you would like the refill called. Upon approval by the physician, your prescription will be called in for you.
Generally, we cannot prescribe medications or make a diagnosis without seeing you in the office. This practice provides you with thoughtful, safe medical care.

PRE-AUTHORIZATION REQUIREMENTS: Your insurance company may require pre-authorization to qualify for insurance coverage for certain services rendered by your physician. It is your responsibility to obtain pre-authorization from your insurance company.

RELEASE OF YOUR MEDICAL RECORDS: We will release your medical records from this office upon your written permission only, to yourself or anyone of your choice that includes chart notes or labs per your request. Any other doctor's records or hospital records must be obtained from them. We cannot release them.

SERVICES FROM INDEPENDENT PROVIDERS BILLED SEPARATELY: In many instances, your physician may order services and testing, which are provided by organizations which are independent from our office. Such organizations include laboratories and pathologists, x-ray facilities and radiologists, consulting physicians, independent procedure facilities and hospitals. These organizations and physicians will directly bill you and your insurance company for their services. Our office may provide them with billing information. Most only bill primary insurance. If your insurance requires you to use a particular lab or organization it is your responsibility to let us know that information and remind us each time the need arises as we have no way of knowing what your insurance requires. This office is not responsible for your billings from these other organizations. Contact them directly with any questions on their billing.

To aid with keeping costs for medical care down, we ask that you:
Pay your portion of your charges at the time of your visit. Please provide positive ID, Proof of your insurance and let us know if your deductible has been met.

Cancellation/ No Show Policy for Doctor Appointment We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company**. Continued No showing for appointments and non compliance may result in dismissal from care.

I have read and agree to these standards while in the care of Dr. Chester and the staff of Caring For Women.

Signature_____Date_____

CARING FOR WOMEN
Complete Women's Care
2841 DeBarr Rd, Suite 37
Anchorage, Alaska 99508

HIPAA Notice of Privacy Practices

Effective Date: 09/23/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care.Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief.We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information 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 copy this Health Information, you must make your request, in writing, to **Caring for Women, 2841 DeBarr Road, Suite 37 Anchorage, Alaska 99508**. We have up to 30 days to make your Protected Health Information 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 of federal needs-based benefit 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 an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the 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 **Caring for Women, 2841 DeBarr Road, Suite 37 Anchorage, Alaska 99508**.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **Caring for Women, 2841 DeBarr Road, Suite 37 Anchorage, Alaska 99508**.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to **Caring for Women, 2841 DeBarr Road, Suite 37 Anchorage, Alaska 99508**. We are not required to agree to your requestunless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to **Caring for Women, 2841 DeBarr Road, Suite 37 Anchorage, Alaska 99508**. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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. To obtain a paper copy of this notice, please ask our front desk and we will be happy to give you an immediate copy.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact **Caring for Women, 2841 DeBarr Road, Suite 37 Anchorage, Alaska 99508**. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

CARING FOR WOMEN
Complete Women's Care
2148 DeBarr Road, Suite 37
Anchorage, AK 99508
279-2229-fax 279-3817

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health Information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ **Date:**_____/_____/_____
Month Day Year

Relationship (if not signed by patient)

_____

Internal use only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

2841 DeBarr Road, Suite 37
Anchorage, AK 99508
907-279-2229 fax 279-3817

INDIVIDUAL CONSENT

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS

I, _____, **understand** that as a part of my healthcare, this practice originates and maintains 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 serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

SIGNATURE _____

DATE _____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Height: _____ **Weight:** _____ **Age of First Period:** _____ **Age of First Child (if applicable):** _____
Are You Menopausal: Yes or No **Have you ever used Hormone Replacement Therapy?** Yes or No
Has anyone in your family had genetic testing for a hereditary cancer syndrome (Ex: BRCA or Lynch)? Yes or No

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandfather 65 yrs*
Y	N	Breast cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Male breast cancer				
Y	N	Are you of Jewish descent?				

COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Prostate Cancer (BRCA)				
Y	N	Pancreatic Cancer (Col/BRCA)				
Y	N	Melanoma (BRCA)				
Y	N	Other Cancers				

Patient's Signature: _____ Date: _____

For Office Use Only:
BRCA/Lynch Testing Indicated?: YES NO
Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED
Follow-up appointment scheduled: YES NO Date of Appointment: _____

Provider Signature: _____ Date: _____

BRCA – Personal or Fam. History

One person with (out to 2nd degree)
- Breast Cancer at 45 or younger
- Ovarian Cancer at any age
- Male breast cancer any age
- Breast Cancer + Jewish Heritage
- Bilateral Breast at 50 or younger
- Triple Neg Br.Ca. at 60 or younger

BRCA – Personal or Fam. History

Two persons with (out to 3rd Degree)
- 2 Breast Cancers (one at 50 or younger, 1 @any age)
- Breast & Ovarian (any age)

Three Persons with (out to 3rd degree)
- Breast and/or Ovarian and/or Pancreatic and/or Aggressive Prostate (any age)

Lynch Syndrome (Colon/Endo)

Personally affected with:
- Colon or Endometrial at < 50 or younger

Family History of Colon, Endometrial, + another Lynch Cancer
(gastric, ovarian, brain, kidney, small bowel)
- 2 or more Lynch cancers, 1 dx < 50
- 3 or more Lynch cancers, any age

CARING FOR WOMEN, P.C.

GYNECOLOGIC INTAKE HISTORY

Name: _____ Birthdate: _____ Date: _____

Established Patient ☐ New Patient ☐ Consult: Y N Referred by _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

	Currently	Past	COMMENTS
1. Constitutional			
Weight loss			
Weight gain			
Fever			
Fatigue			
2. Eyes			
Double vision			
Spots before eyes			
Vision changes			
3. ENT/Mouth			
Ear aches			
Ringing in ears			
Sinus problems			
Sore throat			
Mouth sores			
Dental problems			
4. Cardiovascular			
Painful breathing			
Chest pain			
Difficult breathing on exertion			
Swelling of legs			
Palpitations of heart			
5. Respiratory			
Wheezing			
Spitting up blood			
Shortness of breath			
Cough, chronic			
6. Gastrointestinal			
Diarrhea, frequent			
Bloody stool			
Nausea/vomiting			
Constipation			
7. Genitourinary			Age periods started _____
Blood in urine			Duration of periods _____ days.
Pain with urination			Periods – Heavy _____ Moderate _____ Light ____
Urgency			Cramps for _____ days
Frequency of urination			Cramps – mild _____ Moderate _____ Severe ____
Incomplete emptying			
Stress incontinence			
Abnormal periods			
Painful intercourse			
8. Musculoskeletal			
Muscle weakness			
9. Skin/breast			
Pain in breast			
Discharge			
Masses			
Rash			
Ulcers			
10. Neurological			
Dizziness			
Seizures			
Numbness			
Trouble walking			
11. Psychiatric			
Depression			
Crying, frequent			
12. Endocrine			
Dry skin			
Abnormal thirst			
Hot flashes			
13. Hematologic/lymphatic			
Bruises, frequent			
Cuts do not stop bleeding			
Enlarged lymph nodes			
14. Allergic/Immunologic			
Allergies			
Drugs, other			

PERSONAL PAST HISTORY

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression / anxiety		
Kidney Infections / stones			Anemia / blood transfusions		
Tuberculosis			Seizures / convulsions / epilepsy		
Venereal Disease			Bowel trouble		
Heart trouble / murmur			Glaucoma		
Diabetes			Arthritis / joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis / yellow jaundice		
Rheumatic Fever			Thyroid Disease		

FAMILY HISTORY

ILLNESS	YES	RELATIVE
Diabetes		
Stroke		
Heart Disease		
High Blood Pressure		
Drinking Problem		
Breast Cancer		
Colon Cancer		
Ovarian Cancer		

Mother – Living ___ Deceased ___ Cause_____
Father – Living ___ Deceased ___ Cause _____
Siblings: # living _____ # Deceased _____
Cause _____

OPERATIONS / HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES / ILLNESSES

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

Tetanus	Date	Pneumonia	Date
Flu shot	Date	TB Skin Test	Date

OB / GYN HISTORY

Births	Number	Abortions	Number
Miscarriages	Number	Living Children	Number

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

SOCIAL HISTORY

HABITS

Smoking Yes _____ No _____ Packs per day _____ Years _____
Alcohol Yes _____ No _____
Drug Use Yes _____ No _____ Are you, or is anyone in your home, being hit or abused? _____
Seat Belt Use Yes _____ No _____
Regular Exercise Yes _____ No _____

PERSONAL PROFILE

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____
Number of Living Children _____
Number of people in household _____
School Completed : High School _____ College _____ Graduate Degree _____ Other _____

I have had Herpes Y N
Venereal Warts Y N
Chlamydia Y N
Gonorrhea Y N

Completed by: Patient _____ Office Nurse _____ Physician _____

Signature of Patient _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Subsequent Review of History

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Caring for Women P.C. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____I **do not** authorize Caring for Women P.C. to release any or all information concerning my medical care to any individual except as set forth above.

_____I **authorize** Caring for Women P.C. to verbally release any or all information concerning my medical care to the following individuals.

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Patient Signature	Date

_____	_____	_____
Print Patient Name	Date of Birth	Social Security #
_____		_____
Office Witness Signature		*Date*