Fair Oaks Women's Health
Specialists in Obstetrics & Gynecology
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

www.fowh.com
www.pasadenapregnancy.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Contents of Gyn Forms Packet
[This packet is designed to be printed ONE-SIDED.
Please DO NOT print this on two sides. Thank you.]

We know that this is A LOT of paperwork and for this we apologize. This is only for NEW patients to the practice. Thank you very much for your time.

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WELCOME TO OUR PRACTICE

Thank you for choosing Fair Oaks Women's Health for your ob/gyn medical care! In preparation for your upcoming appointment, we would like you to get a head start with some of the paperwork and also tell you a bit about our practice. Our services include comprehensive medical care for women of all ages, including well woman exams, contraception, STD testing, routine and high-risk prenatal care and delivery, bio-identical hormone therapy, menopause management, gynecologic and laparoscopic surgery (including robotic surgery) and more. We also have the MonaLisa Touch® vaginal laser used to successfully treat vaginal dryness and painful intercourse due to loss of estrogen from menopause.

Marina's Oasis Medi-Spa

Marina's Oasis, our medical aesthetics center, provides a wide range of non-invasive corrective services to enhance the health and appearance of your skin. We proudly offer the Liquid Face Lift with Botox® Cosmetic, Juvederm® XC dermal fillers (Ultra, Ultra Plus, Voluma, and Volbella), and Kybella®; IPL PhotoFacials and non-ablative laser PhotoFractionals; adult and teen clinical skin care (Microneedling, Designer peels, Dermaplaning, and MicroDerm); Viora Reaction® skin tightening and body contouring; and spider vein removal. For more information call Marina Jick, MSN, FNP at 626-MY-OASIS (626-696-2747) or go to www.marinasoasis.com.

EMR (electronic medical record)

Our practice uses a computerized health record, called an EMR. It takes time to enter your information into the computer. **It would be very helpful if you would complete your New Patient forms and then mail (or fax or e-mail) them to us before your appointment.** If you do not send these forms, your visit could be delayed while we update the computer before you see the doctor. Email your forms to: obgyn@fowh.com.

Please arrive early for your FIRST appointment

It takes time time to enter or update your personal, insurance and health information. At your first visit we scan your driver's license and insurance card for entry into our EMR. *We guarantee to keep all of your personal information private.* This is the law (a Federal law called HIPPA).

We charge for a "no-show"

Please call us at least 24 hrs in advance if you are unable to keep your appointment. There is a $25 charge for a no-show appointment (waived if you make and keep the next appointment). When you do not show up or call ahead to cancel, we have lost the chance to have another patient use that appointment time.

Parking – we do not validate

Please note that you pay the cashier BEFORE returning to your car. To save money (but with a little more walking) some patients park in the Huntington Hospital EAST Parking structure, a building just south of ours. The entrance is off Fairmount Ave. across from the Emergency Dept.

Lab

We have an on-site lab, called Primex. This is where most of our standard lab tests are run except pap smears and biopsies. It is your responsibility to know which lab your insurance is contracted with. **If your insurance requires you to use a different lab than mentioned above, please let us know.**

Feel free to call us at any time if you have any questions. Call (626) 304-2626.
Thank you for trusting us with your medical care. We look forward to seeing you!

PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY _____ [Office use: (HH Med Rec # _____]

PATIENT LAST NAME _____ FIRST NAME_____ M.I. _____

PREFERRED NAME _____ MAIDEN NAME_____

DATE OF BIRTH _____ SSN# _____ RACE _____

MARITAL STATUS M S D W _____ DRIV LIC. # _____ RELIGION _____

ETHNICITY (H, NH or D) _____ (H - Hispanic, NH - Non-Hispanic or D- Declined)

ADDRESS _____ (PO Boxes Not Allowed)

ZIP _____ CITY _____ STATE_____

HOME PH.# _____ WORK PH.# _____ CELL PH.# _____

FAX # _____ email: _____

PREFERRED PHONE NUMBER M-F 9-5 (**circle** one): **HOME** **WORK** **CELL**

Are you employed? _____ If yes, EMPLOYER NAME _____

EMPLOYER PH. # _____ FAX # _____

ADDRESS _____

ZIP _____ CITY _____ STATE_____

YOUR OCCUPATION _____

(If you are married, we need your spouse's information, please)

SPOUSE/SIG OTHER NAME _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

(if different) HOME PHONE _____ WORK PHONE _____

HOW DID YOU HEAR OF US? _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY STREET ADDRESS: _____

PHARMACY CITY,STATE,ZIP _____ PHONE _____

Do we have permission to import your medication history using our electronic prescription software? YES NO

EMERGENCY CONTACT INFORMATION (not your spouse/sig other)

CONTACT NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR VOICE MAIL or e-MAIL?

Please sign below if you give us permission to leave messages (such as test results) on your voice mail or e-mail:

SIGNED _____ DATE _____

INSURANCE INFORMATION FORM

Please take a few minutes to complete this form. All information provided is completely confidential. Thank you. We use this information only for medical insurance verification and billing.

PATIENT NAME _____ DATE _____

_____ I am insured under my own plan _____ I am insured under someone else's plan

DATE COVERAGE EFECTIVE _____

NAME OF POLICY HOLDER _____

SOCIAL SEC. NUMBER of POLICY HOLDER _____

INSURANCE COMPANY NAME _____

GROUP NUMBER _____ ID NUMBER _____

CLAIM FILING ADDRESS _____

ZIP _____ CITY _____ STATE_____

BILLING PH. # _____

CONTACT NAME _____ e-MAIL _____

PLAN WEB SITE _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

By signing below, I authorize Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to the doctor all insurance payments for medical services rendered and all major medical benefits. *I understand that I am personally obligated to pay for all medical services rendered, regardless of whether or how much my insurance company has paid.*

NAME _____ DATE _____

SIGNATURE _____

Insurance Verification

_____

_____

_____

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Office and Financial Policies

We would like to thank you for choosing Fair Oaks Women's Health as your women's health care provider. This document explains our current office and financial policies. It is important that you read and agree to these policies.

No-Shows: If you cannot keep your scheduled Gyn appointment, please call our office at least 24 hours in advance to reschedule. This will allow us to offer that time to another patient. Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment is a **no-show** and may result in a charge of $25. This fee may be waived depending on your circumstances and will be waived if you make and keep your next appt.

Late Arrivals: You are expected to arrive on time for your scheduled appointments. New patients should plan to arrive 30 minutes early to allow for completing forms and updating your electronic medical record in the computer. If you are more than 15 minutes late, we may have to reschedule your appointment.

Fair Oaks Women's Health accepts Cash, Personal Checks, MasterCard, Visa, American Express Cards and ATM debit cards as payment for services rendered.

Financial Responsibility: Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.

Insured Patients: Please bring your insurance card with you to your appointment. If your insurance plan requires an office visit co-pay, this will be collected at the time of service. The co-pay cannot be waived by our office; it is a requirement placed on us by your insurance carrier. You are financially responsible for any co-insurance, deductible or non-covered service. If you are a member of a health plan that Fair Oaks Women's Health participates with, we will submit a claim to your insurance company on your behalf.

Balance Due: Once we have received payment along with an Explanation of Benefits (EOB) from your insurance plan, you will receive a statement from our office indicating what your insurance has paid. Any remaining balance will then be due and payable. Patients with large deductibles will be asked to pre-pay a portion of their known medical expenses (for example, pregnant or gyn surgery patients)

Non Insured Patients: Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager.

Medicare Patients: You are personally responsible for your deductible, co-insurance and any services that Medicare deems as "Medically Unnecessary". Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for certain services.

Returned Checks: A $25 fee will be assessed for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

Disability Forms: A $20 fee will be charged for processing and mailing each disability form. These forms have become longer and more complicated and require a lot of administrative time to handle.

Medical Records Request: There is a $30 fee for a medical records request. Payment for these records will be collected prior to records being released. A complimentary copy of your records will be sent to the physician of your choice. This fee can be waived for hardship, please speak to the office manager.

Collection Accounts: Fair Oaks Women's Health reserves the right to turn an account over to collections if it is deemed that the account is in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collections fees, including court costs, collections agency fees and attorney's fees incurred by us in enforcing the terms hereof, whether or not formal legal proceedings are commenced.

Financial Hardship: We understand that sometimes it is a hardship to pay your medical bills timely. Please meet with our Office Manger so we can work out a payment plan. Ignoring medical bills is not advisable. Let us know your situation so we can work with you.

Pharmacy Benefits: Our electronic medical record allows us to download your prescription medication history directly into your electronic chart. This step allows us to have more accurate information about your medications (name off medicine, dosage) and saves us from having to enter your medications separately.

Newborn Circumcisions: Many insurance plans do not pay for newborn circumcisions. If the doctor performs a newborn circumcision and it is denied by your insurance, you will owe the complete fee.

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Acknowledgement of Receipt of and Agreement with the Office and Financial Policies

I have read and I understand the handout, ***Office and Financial Policies***.

I authorize the physicians of Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to Fair Oaks Women's Health all insurance payments for services rendered and all major medical benefits.

I agree to allow pharmacy benefit information (my medication history) to be electronically downloaded into my electronic medical record. _____ (initials).

I understand that I am personally obligated to pay for all medical services rendered regardless of whether or how much my insurance company has paid.

By signing below, I am stating that I understand and I agree to the above policies.

NAME _____ DATE _____

SIGNATURE _____

(Please sign and return this page to us. We will provide a copy upon request).

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Explanation of Medical Billing

For all medical services we provide, we will submit a claim to your Insurance Plan. It is extremely important that we have accurate information about your plan. After we receive the EOB (explanation of benefits form), we will determine the amount, if any, that you still owe. Your statements will reflect this amount.

Introduction

Medical insurance involves 3 common forms of payment to physicians.
These are the **co-pay**, the **deductible** and the **co-insurance**.

The fee

Medical billing is called fee-for-service. The doctor provides services, and for each service, there is a fee (or a charge). The amount you owe is usually less than the full fee due to fee-reduction contracts between the doctor and your health insurance company. Contrary to what many people believe, insurance does not "cover everything".

The co-pay

The co-pay is the amount of money that you owe up front for every doctor visit. Each insurance plan is different. The co-pay might vary in amount or there might be none. The co-pay needs to be paid in advance at the time of your visit. Some co-pays are as high as $50.

The deductible

Many patients have an annual deductible. This is money that the insurance company will determine is owed to the physician, but that the patient has to pay. When a balance due is applied to your deductible, you owe this money to the practice. *See the example below*.

The co-insurance

This is the percentage of the fee that is owed to the practice based on your plan. The amount depends on what the insurance has approved for payment. You owe the co-insurance amount to the practice. *See the example below*.

Example using the above terms

You go to the doctor for a problem. The visit ***fee*** is $150. Your ***co-pay*** is $10 and this is paid at the time of the visit. A claim is filed with your insurance company. They approve a payment of $100.00, but you have a 20% ***co-insurance***.

The $100 is what your insurance has approved for the full payment for this visit. You have already paid $10 of this as your co-pay so the insurance owes $90. You have a ***co-insurance*** of 20%, so they will only pay 80% of the $90. Thus, they will pay only $72. Your co-insurance is $18. So you have paid $28 total ($10 co-pay plus the 20% or $18 co-insurance) and your insurance has paid $72.

If you have an unmet ***deductible***, the insurance will "apply" the entire $90 to your deductible. In this case, you owe the full $90 (but your deductible has been credited or reduced by $90).

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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.

HIPPA PRIVACY NOTICE

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer (see end of Notice).

How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. (We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.) We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice. However, this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the paragraphs headed treatment, payment, health care operations, and notification and communication with family, of this Notice of Privacy Practices, or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area. We will also post the current notice on our website (www.fowh.com)

Complaints. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services in Washington, DC. You will not be penalized for filing a complaint.

Privacy Officer: Mercedes Bin
Effective July 2016

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Our privacy officer is Mercedes Bin, the office manager. Her phone number is (626) 304-2626.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

e-mail address: _____

Signed: _____ Date: _____

Print Name: _____ Phone: _____

☐ If not signed by the patient, please indicate relationship of who signed:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

DISCLOSURE TO OTHERS

I hereby authorize Fair Oaks Women's Health to discuss/reveal the following personal protected health information with the person(s) listed below:

( ) Any or all of my medical care, treatment and/or test results

( ) Same as above except: _____

( ) Only the following: _____

Authorized person(s):

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____

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NEW GYN PATIENT HISTORY FORM
(OB PATIENTS, please DO NOT USE THIS FORM. Thanks.)

TODAY'S DATE _____ Your age_____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First)_____ (M.I.) _____

REFERRED HERE BY _____

YOUR PAST MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate with an X or a √)
Thank you for answering all of the following questions. Your health is important to us.

Breast Conditions
_____ Recent Mammogram When? _____
_____ History of Abnormal Mammogram
_____ Breast Cancer
_____ Breast Implants
_____ Fibrocystic Breast
_____ Other _____

Gyn Conditions
_____ Abnormal Pap Smear
_____ Endometriosis
_____ Fibroids
_____ Herpes (circle which type- oral and/or genital)
_____ HPV (Human Papilloma Virus)
_____ Menopause
_____ Ovarian Cysts or PCOS (polycystic ovary)
_____ Severe PMS
_____ Other _____

Heart or Circulation Conditions (Cardiovascular)
_____ Blood Clot (DVT or Pulmonary Embolism)
_____ Fainting (Syncope)
_____ High Blood Pressure
_____ Varicose Veins
_____ Other _____

Endocrine (Glandular) Disorders
_____ Diabetes (circle which type: Type 1 or Type 2)
_____ Pituitary Gland Disease
_____ Thyroid Disease
_____ Other _____

Immune System Diseases
_____ Lupus or Rheumatoid Arthritis
_____ Other _____

Gastrointestinal (GI) Problems
____ Blood in Stool
____ Crohn's Disease or Ulcerative Colitis
____ Hemorrhoids
____ Hepatitis
____ Irritable Bowel Syndrome
____ Had Colonoscopy? When? _____
____ Other _____

Blood (Hematologic) Disorders
____ Anemia
____ Clotting Disorder
____ Sickle Cell Trait or Disease
____ Thalassemia
____ Other _____

Musculoskeletal Disorders
____ Fractures or Broken Bones
____ Arthritis or Joint Pain
____ Severe Back Pain or Back Disease
____ Other _____

Neurologic Disorders
____ Migraines or Severe Headaches
____ Seizure Disorder (Epilepsy)
____ TIA or Stroke
____ Other _____

Mental Health Conditions
____ Bipolar (Manic-Depressive)
____ Nervous Breakdown
____ OCD (Obsessive-Compulsive)
____ Severe Anxiety or Panic Attacks
____ Severe Depression or h/o Postpartum Depr.
____ Other _____

Respiratory (Lung) or ENT Disorders
____ Allergies, Hay Fever
____ Asthma
____ Bronchitis/Pneumonia
____ Lung Cancer
____ Sinusitis or Sinus Problems
____ Sleep Apnea
____ Other _____

Urinary (Urological) Disorders
____ Frequent Bladder Infections
____ Kidney Stones or Other Problems
____ Other _____

Skin Conditions
____ Acne (severe)
____ Eczema
____ Excess Hair Growth
____ Hives
____ Psoriasis
____ Other _____

What is your height? _____

What is your recent weight? _____

REVIEW OF SYSTEMS – RECENT ABNORMAL SYMPTOMS

(Are you currently experiencing any of the following symptoms to a significant degree?)
(If so, please indicate with an X or a √)

General
____ Fatigue or Weakness
____ Fever, Chills or Sweats
____ Loss of Appetite
____ Unexplained weight gain or loss

Eyes, Ears, Nose and Throat
____ Dizziness
____ Nose Bleeds
____ Sore Throat
____ Vision or Hearing Changes

Breasts
____ Breast Lump or Lumps
____ Breast Pain or Tenderness
____ Nipple Discharge (other than white)

Cardiovascular
____ Chest Pain or Tightness
____ Irregular Heartbeat or Palpitations

Respiratory
____ Chronic Coughing
____ Shortness of Breath
____ Wheezing

Gastrointestinal
____ Diarrhea (watery stool)
____ Heartburn
____ Nausea or Vomiting
____ Severe Constipation

Urinary
____ Burning with Urination
____ Frequent Urination
____ Urgency of Urination
____ Leakage of Urine
____ Waking at night 2 or more times to urinate

Gyn
____ Bleeding After Intercourse
____ Bleeding Between Periods
____ Bumps or Sores in Genital Area
____ Cycles Longer than 35 days?
____ Heavy Flow more than 3 days?
____ Pain Before or During Periods
____ Pain with Ovulation
____ Pain during intercourse
____ Periods last 8 or more days
____ Severe Pain or Cramps with Periods
____ Severe PMS Symptoms
____ Vaginal Discharge
____ Vaginal Itching, Burning or Dryness

Skin
____ Itching
____ Moles or Sores
____ Rash

Neurologic
____ Dizziness
____ Headaches
____ Memory Problems

Musculoskeletal
____ Joint Pain (Back, Knee, Wrist, Hip)
____ Joint Swelling
____ Muscle Cramping or Pain

Endocrine (Glandular)
____ Excessive Hair Growth
____ Excessive Hair Loss
____ Intolerance to Heat or Cold
____ Low Sex Drive

Psychiatric
____ Excessive Anxiety, Worries, Stress
____ Severely Depressed
____ Feeling Out of Control

PAST SURGERY or HOSPITAL ADMISSIONS

List all Surgeries or Hospital Admissions - EVER	Year

CURRENT PRESCRIPTION MEDICATIONS YOU ARE TAKING

Medication name, dosage (amount) and reason (include meds "as needed")
Recent Vaccines (Please enter here):

PHARMACY INFO (so we can E-prescribe for you)

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____ Fax # _____

Do we have permission to import your medication history using our electronic prescription software? YES NO

VITAMINS, HERBS AND SUPPLEMENTS YOU ARE TAKING

Product name and how often (include dosage if known)

ALLERGIES (circle choices)

If yes, please list all allergies and your allergic reaction

Do you have ANY allergies? NO ALLERGIES Allergic to Latex? YES NO

Allergic to	**Reaction**

FAMILY MEDICAL HISTORY

FOR THE ITEMS BELOW, PLEASE CONSIDER the following relatives: *(Yourself, Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, and Nephews).* This is a screening method to see if you are at increased risk for having a genetic mutation that can cause hereditary cancer.

CANCER RISK ASSESSMENT			Please Answer Yes or No, indicate age, and who has that specific condition.
Y	N	Have **YOU** or a **Family Member** ever been diagnosed with **Breast Cancer**?	
Y	N	Have **YOU** or a **Family Member** ever been diagnosed with **Colon Cancer or Endometrial Cancer**?	
Y	N	Have **YOU** or a **Family Member** had ten or more lifetime colon polyps (colorectal adenomas)?	
Y	N	Are **YOU** of Jewish ancestry *with* **Breast Cancer** in any **Family Member**?	
Y	N	Have **YOU or ANY FAMILY MEMBER** been diagnosed with **Ovarian Cancer** at any age?	
Y	N	Do you have **3 or more Family Members** with any of the below cancers on the same side of the family diagnosed at any age? ***Cancers: Breast, Colon, Endometrial (Uterine)***	
Y	N	Are there any **Men** in your family that have been diagnosed with **Breast Cancer**?	

OTHER CONDITIONS	Please CIRCLE CONDITION (on the left) and indicate below who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, BLOOD CLOTS, STROKE	
3. ASTHMA or OTHER LUNG DISEASE	
4. KIDNEY DISEASE or KIDNEY STONES	
5. GYN DISEASES, OVARIAN, CERVICAL OR UTERINE CANCER, UTERINE FIBROIDS	
6. MUSCULOSKELETAL DISEASES, OSTEOPOROSIS OR OSTEOPENIA	
7. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
8. SEVERE DEPRESSION or OTHER MENTAL HEALTH CONDITION	
9. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
10. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
11. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	

Comments:

_____

Patient Name _____

SOCIAL HISTORY

Do you get 3 servings daily of dairy products (milk, yogurt, cheese, cottage cheese)? _____

Type of Exercise: _____ How Often? _____

Alcohol Intake: NONE or _____

Smoking History: NONE or _____

Drug Use: NONE or _____

Hazardous Exposures: NONE or _____

Your Occupation: _____

MENSTRUAL HISTORY

AGE of FIRST MENSTRUAL PERIOD _____ *CYCLE LENGTH (28 days or ?) _____

# of DAYS of BLEEDING during a *PERIOD _____ # days heavy_____ # days light/spotting _____

DATE of LAST NORMAL MENSTRUAL PERIOD (if abnormal, describe) _____

BIRTH CONTROL METHOD _____ If none, please enter reason _____

LAST Pap Smear (MM/YY) _____ By who? _____

(***period** means # of bleeding days; **cycle length** means total # of bleeding & non-bleeding days until the next period begins)

PREGNANCY SUMMARY (how many…?)

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Comments: _____

_____

PREGNANCY DETAILS

Child's Birthdate	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location

Fair Oaks Women's Health
Specialists in Obstetrics & Gynecology
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

www.fowh.com
www.pasadenapregnancy.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization allows the release of confidential medical records to Fair Oaks Women's Health.

1. Patient Information

_____
Patient Name *Date of Birth*

_____
Street Address *City* *State* *Zip*

_____
Phone *e-mail* *Fax*

2. TO: Healthcare Provider or Facility

_____
Name of MD or Medical Facility *Address* *City* *State* *Zip*

_____
Phone *Fax*

3. Purpose of Records/Medical Information Release: _____

4. Please RELEASE my medical information to:

Fair Oaks Women's Health
625 S. Fair Oaks Ave., Suite 255, Pasadena, CA 91105
Phone: 626-304-2626 Fax: 626-585-0695 e-mail: obgyn@fowh.com

5. Authorization

I hereby authorize the above healthcare provider or facility to release information regarding my medical history, illnesses or injuries; consultations, prescriptions, treatments, diagnoses or prognoses; including images, correspondence and/or medical records; by means of mail, fax or other electronic methods.

I authorize the release of the information specified below:

- ☐ My health information related to drug/alcohol/substance abuse.
- ☐ My health information related to psychological/psychiatric/mental health.
- ☐ My health information related to HIV/AIDS/STD diagnosis and/or treatment.
- ☐ My health information related to the following treatment or conditions:

  _____
- ☐ All my health information including substance abuse, mental health and HIV/AIDS/STD related.

6. Duration: This authorization is effective immediately and will remain in effect until _____
Date

7. Restrictions

Permissions for further use or disclose of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

_____
Signature of Patient *(or legal representative)* Patient name (print) Date

_____
Witness signature Witness name (print) Date