Galisteo Advanced Gynecology Information Form

Name: _____

Date of birth: _____SSN#_____

Address: _____

City: _____ State: _____ Zip: _____

Home#(____)_____Work#(____)_____Cell(____)_____

Employer:_____

Spouse/Partner:_____Phone(___)_____

Relative Not Living With You: _____Phone(__)_____

Primary Care Physician: _____Phone(__)_____

Insurance Company:_____

Policy#_____Group#_____

Name of the Policy Holder:_____ Their DOB:_____

Policy Holder Address:_____

Your Relation to the Policy Holder:_____

I (patient) Will Pay for Visits or Copays by Cash, Check, or Credit Cards

We Accept Visa, Discover, and Master Card

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I understand that there will be a 1.5 percent interest fee on any unpaid balance due to me that is over 60 days. I have read and completed all the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

I understand that I will be charged a 50 dollar fee for cancellation that is less than 24 hours notification, as well as if I don't show for my appointment.

_____ _____

Signature **Date**

Galisteo Advanced Gynecology
2055 S. Pacheco Street, Suite 300
Santa Fe, NM 87505
Phone (505) 984-2300
Fax (505) 988-1940

PATIENTS CONSENT OF DISCLOUSURE

I hereby give consent to Advanced Gynecology and all health care providers furnishing care with this office to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

As the patient, you may cancel this consent at any time. Your cancellation must be in writing signed by you or on your behalf and delivered to the address at the top of this form. The cancellation may be delivered in person or by mail but will only be effective when the document is received by Advanced Gynecology. Your cancellation will not be effective to the extent that Advanced Gynecology or others have acted in reliance upon the Patients Consent of Disclosure.

You, as the patient, have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment, or health care operations. Advanced Gynecology is not required to grant your request, however, if we do, the restriction will be obligatory to us.

Advanced Gynecology posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Privacy Policy before you sign this consent form.

Advanced Gynecology reserves the right to amend the terms of our Privacy Policy. You may obtain a copy of the current policy by contacting our Practice Manager, @ 984-2300

Patient's Signature: _____ *Date:* _____

Patient's Printed Name: _____

If you are signing as the patient's representative or guardian:

Your Name (Please Print) _____ *Relationship:*_____

CANCELLATION:

I hereby revoke and void the consent given above:

*Patient's Signature:*_____ *Date:*_____

Patient's Printed Name: _____
If you are signing as the patient's representative or guardian:

Your Name: (Please Print) _____ *Relationship:*_____

Galisteo Advanced Gynecology

In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thank You!

Name: _____ Date: _____

Contraception ___or Non Applicable___

1. What is your current form of birth control? _____
2. When are you planning to have another child? _____
   ___within the next year ___within the next 5 years
   ___within the next 10 years ___ my family is complete

3. Are you finished having children?
   Yes or No

Menstrual Periods ___or Non Applicable ___

1. How long does your average monthly period last? _____days
2. Do you ever feel as though your periods impact the quality of your life? Yes or No
3. Do you ever experience irregular or inconsistent bleeding patterns?
   Yes or No

Urinary Health___ or Non Applicable___

1. Do you ever leak urine when you cough, laugh or sneeze?
   Yes or No
2. Do you ever feel as though you have to urinate urgently
   Yes or No
3. Do you feel like you have to urinate too frequently?
   Yes or No
4. Do you ever experience painful urination?
   Yes or No

Allergies to Medications/ Food/ Environment	Reaction

Current Medications	Dose	Instructions	Reason Used

Are you using birth control? Yes___ No___
Diaphragm ____Pills ____Condom ____Sponge ____Rhythm ____Withdrawal ____IUD ____ Pills____ Norplant (Implants) ____ Injections____ Tubal Ligation____ Vasectomy____ Implanon (Implants) ____ Nuva Ring ____Ortho Evra____ or Other_____

First day of last period? (or age of menopause)? _____
Age of first period? _____Are your periods regular? Yes____ or No____
Is there bleeding between periods? Yes____ or No____
How often do your cycles occur? _____
For how many days do you bleed? _____
Flow is _____Scant_____Mild_____Moderate_____Severe_____incapacitationg_____
Other symptoms with periods? _____
Date of last Pap smear? _____Have you had an abnormal pap smear? Yes____ or No____
Has this been treated? Yes____ or No____ and how were you treated? _____
Do you examine your breast regularly? Yes____ or No____
When was your last Mammogram? _____

Do you have and concerns about your breasts? Yes____ or No____

_____

When was your last Bone Density? (If any) _____ Result_____

Galisteo Advanced Gynecology LLC

Confidential Medical History

Past Medical/Surgical History (Including Injuries)	Date	Treatment

Have You Had?

Pain with intercourse? No____Yes____

Bleeding with intercourse? No____Yes____

Concerns about vaginal discharge? No____Yes____

Leaking of urine? No____Yes____

Pelvic infections? No____Yes____

Sexually transmitted diseases? No____Yes____

Total number of pregnancies

Full Term	Premature	Ectopic	Miscarriage	Abortion	Stillborn	Live at Birth	Live at Present

Pregnancy Details

Preg #	Sex	Month/Year	Number of weeks	Weight	Hrs of Labor	Delivery Type	Obstetrical/National Problems	Delivery Doctor

Name _____Birthday_____Age_____Date_____

Family History

Disease	Yes/No	Family Member	Family Members Name	Age of Death	Cause of Death
Cancer of Breast					
Cancer of Ovary					
Cancer of Uterus					
Cancer of Cervix					
Diabetes					
Tuberculosis (TB)					
Heart Disease					
High Blood Pressure					
Other:					

Social History

Primary Language Spoken_____ Race_____

Education_____ Degree Obtained_____

Do you smoke? Yes___ No___ If yes, type of tobacco? _____ Number of years? _____

Do you drink alcohol? Yes___ No___ If yes, type of alcohol? _____

How often? _____Amount? _____ Last drink _____

Do you consume caffeine? Yes___ No___

Do you use recreational drugs? Yes___ No___ if yes, what kind? _____

How many sexual partners do you have? _____None_____One_____2-5_____5+_____

Have you been exposed to sexual or physical violence or abuse? Yes___ No___

Patient Name _____

Review of System

Do you now have any of the following problems?

Constitutional: Yes No (e.g. headaches, fatigue, fever weakness, insomnia, weight loss/ gain, other _____) If yes, explain: _____

Ear/ Nose/ Throat: Yes No (e.g. hearing loss, ringing in the ears, sinus problems, nasal congestion, sore throat, hoarseness, vertigo, other_____) If yes,_____ explain:_____

Respiratory: Yes No (e.g. asthma, cough, shortness of breath, wheezing, pain with breathing, blood in sputum, TB exposure, other_____) if yes, explain: _____

_____

Cardiovascular: Yes No (e.g. palpitations, rapid heart rated, irregular heart rhythm, chest pain or pressure, shortness of breath with exertion, calf pain with exercise, leg swelling, other _____) If yes, explain:_____

Gastrointestinal: Yes No (e.g. trouble swallowing, heart burn, decreased appetite, increased appetite, nausea, vomiting, black tarry stools, constipation, diarrhea, abdominal pain, food intolerance, jaundice, other_____) If yes,_____ explain:_____

Genitourinary: Yes No (e.g. blood in urine, pain with urination, urinary urgency, urinary discharge, genital sores, abnormal menstruation, and other_____) if yes, explain: _____

_____

Integumentary (Skin/Breast) Yes No (e.g. skin color change, skin rash, skin lump, itchy skin, skin ulcer, abnormal hair change, abnormal finger nails, abnormal lesions, hives, sores _____) If yes, explain:_____

Endocrine: Yes No (e.g. cold intolerance, heat intolerance, increased thirst, increased urination, bulging eyes, mass in front of neck_____) If yes,_____ explain:_____

Neurological: Yes No (e.g. headaches, fainting, numbness of extremities, tingling, local weakness, tremors, balance problems, dizziness, vertigo, memory problems, seizures, _____) if yes, _____ explain: _____

Psychological: Yes No (e.g. nervousness, tension, low mood, excessively elevated mood, irritability, hallucinations, frequent nightmares, other_____) if yes, _____ explain: _____

Musculoskeletal: Yes No (e.g. joint pains, joint stiffness, back pain, muscle pain, muscle wasting, night cramps, and easily broken bones_____) If yes, explain: _____

Hematological/Lymphatic: Yes No (e.g. enlarged lymph nodes, tender lymph nodes, bleeding, bruising, blood transfusion, other_____) If yes, explain:_____

Allergic/Immunological: Yes No (e.g. hives, seasonal allergies, other_____) if yes,_____ explain: _____