WOMEN'S HEALTH ASSESSMENT

Name _____ Date of Birth ____/____/____ Today's Date _____
Single Married Separated Divorced Widowed Referred By _____

Reason For Visit:

_____
_____
_____

Medical History Have you ever had any of the following?

□Anemia	□Blood Clots in Lungs/Legs	□Chicken Pox	□Pneumonia
□Heart Disease/Attack	□Gall Bladder Disease	□Epilepsy/Seizures	□Tuberculosis
□High Blood Pressure	□Liver Disease/Hepatitis	□Migraines	□Sickle Cell Disease
□Stoke	□Kidney Infections	□Depression/Anxiety	□Thyroid Problem
□High Cholesterol	□Bladder Infections	□Drug or Alcohol Problem	□Blood Transfusion
□Mitral Valve Prolapse	□Pelvic Infections	□Diabetes	□Genetic Condition
□Bleeding Problems	□Arthritis	□Asthma	□Cancer

List all medications you are currently taking, including over-the-counter medications, vitamins and herbals:

_____ _____ _____
_____ _____ _____

List any allergies to medications: _____ □No Known Allergies

Surgical History Please list all surgeries with dates:

_____ _____
_____ _____

Obstetrical History

□Check here if you have never been pregnant

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics, & abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (e.g., preterm labor, diabetes, high blood pressure)	Name / Age

Gyn History

Date of last period: _____
Age of first period ___
Age of last period ___
Cycle length: every ____ days
lasting ____ days

Periods are: □Regular □Irregular □Painful □Not really bothersome

Flow is: □Light □Light to moderate □Moderate to heavy □Very heavy

Are you sexually active? □Yes □No □Never been sexually active

Sexual preference: □heterosexual □homosexual □bisexual

New Partners? □Yes □No
Number of lifetime partners ___

Method of Birth Control: □condoms □pills □patch □vaginal ring □tubal / Essure □IUD □partner with vasectomy □natural family planning □other □none

Gyn History Cont.

Have you ever had any of the following STDs? □Chlamydia □HPV □HIV □Never had any
□Gonorrhea □Syphilis □Hepatitis B
□Herpes □Trichomonas □Hepatitis C

Have you had any of the following? □Fibrocystic breasts □Endometriosis
□Ovarian cysts □Uterine Fibroids

Date of last pap smear _____ □Normal □Abnormal □Never had one
Have you ever needed any of the following for an abnormal pap? □Colposcopy □LEEP/Laser/Conization
□Cryosurgery □No

Date of last mammogram _____ □Normal □Abnormal □Never had one
Date of last bone density _____ □Normal □Ostepenia □Osteoporosis □Never had one
Date of last colonoscopy _____ □Never had one

Family History Please list any close relatives with a history of the following:

	Relative/Age at Diagnosis		Relative
□ Breast Cancer		□ High blood pressure	
□ Ovarian Cancer		□ Diabetes	
□ Uterine Cancer		□ Heart Disease (heart attack..)	
□ Colon Cancer			

Social History

Alcohol Use	□Yes	□No	If yes, _____ drink(s) per day/week/month
Tobacco Use	□Yes	□No	If yes, _____ pack(s) per day for _____ years
Recreational Drug Use	□Yes	□No	Type and frequency _____
Exercise	□Yes	□No	Type and frequency _____
Caffeine	□Yes	□No	If yes, _____ drinks (coffee, tea, soda) per day/week
Sexual Abuse	□Yes	□No	If yes, are you safe now? □Yes □No Counseling? □Yes □No
Physical Abuse	□Yes	□No	If yes, are you safe now? □Yes □No Counseling? □Yes □No
Emotional Abuse	□Yes	□No	If yes, are you safe now? □Yes □No Counseling? □Yes □No

Review of Systems Do you currently have any of the following?

	Comments		Comments
□Yes □No Generally healthy		□Yes □No Frequent urination	
□Yes □No Recent weigh gain / loss		□Yes □No Burning with urination	
□Yes □No Fever		□Yes □No Incontinence	
□Yes □No Vision problems		□Yes □No Urgency	
□Yes □No Sinus problems		□Yes □No Bladder infection	
□Yes □No Hearing loss		□Yes □No Stomach pains	
□Yes □No Chest pain		□Yes □No Vaginal discharge	
□Yes □No Varicose veins		□Yes □No Irregular vaginal bleeding	
□Yes □No Shortness of breath		□Yes □No Pelvic pain	
□Yes □No Chronic cough		□Yes □No Painful intercourse	
□Yes □No Diarrhea		□Yes □No Breast lumps	
□Yes □No Constipation		□Yes □No Back pain	
□Yes □No Blood in stools		□Yes □No Joint/muscle pain	
□Yes □No Heartburn/reflux		□Yes □No Depression/anxiety	
□ None of the above		□ None of the above	

Patient Signature _____ Date _____
Clinician Signature _____ Date _____

Adler GYN
Minimally Invasive Surgery

Patient Registration Form

Name (Last, First, Middle)			SSN #
Date of Birth:	Age:	Marital Status:	Maiden Name:
Address:		City, State	
Patient Home Phone:	Patient Cell Phone:	Patient E-Mail:	
Patient Business Phone:		Patient Occupation:	
Business Address:		City, State:	Zip Code:

Spouse/Parent/Guardian Name (If under age 18)		Employer:	
Address:		City, State:	Zip Code:
Business Phone:	Alternative Phone:	Relationship (Spouse, Parent, Guardian)	
In case of Emergency:		Phone:	
Do you have a living will? Y N	Who referred you to our practice?		

Primary Insurance Company:		Secondary Insurance:	
Address:		Address:	
City, State, Zip Code:		City, State, Zip Code:	
Phone:	Co-Pay:	Phone:	Co-Pay:
Insured Party ID #		Insured Party ID #	
Group ID #		Group ID #	
Name of Insured:		Name of Insured:	
SSN of Subscriber:		SSN of Subscriber:	
Relationship to Patient:		Relationship to Patient:	

*** ***Payment is due at time of service.*** ***

Assignment and Release; I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign to Adler GYN all insurance benefits, if any, otherwise payable to me for my services rendered, I understand that I am fully responsible for all charges not paid by my insurance company. I hereby authorize this practice to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all submissions. I fully understand that any outside lab work will be billed by that lab, independently.

Patient's Signature:	Date:

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HIPPA Form

PATIENT CONSENT FOR USE / DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name:_____
Date of Birth: _____
SSN: _____
Previous / Other Name(s): _____

I understand that the patient's health information is private and confidential. I understand that Adler GYN works very hard to protect patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Adler GYN may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

Adler GYN has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I will have a right to read the "Notice" before signing this agreement.

Adler GYN may update this "Notice of Privacy Practices". If I ask, Adler GYN, will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Adler GYN to limit how the patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Adler GYN does not have to agree to my request. If Adler GYN does agree to my request, I understand that Adler GYN would follow agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing and dating a form that Adler GYN can give me called "Revocation of consent for Use and Disclosure of Health Care Information", or

2) Writing, signing, and dating a letter to Adler GYN. If I write a letter, it must say that I want to revoke my consent to authorize and disclose the patient's personal health information for treatment, payment and health care operations.

If I revoke this consent, Adler GYN, does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Adler GYN's "Notice of Privacy Practices". My signature means that I allow Adler GYN to use and disclose patient's personal health information to carry out treatment, payment, and health care operations.

Patient / Legally-Authorized Signature: _____
Date: _____
Relationship to patient if signed by anyone other than patient:_____

Adler GYN
Minimally Invasive Surgery

HIV & Verbal Authorization Forms

Authorization to VERBALLY Release Patient Information

I, _____, hereby authorize Alf Adler, M. D. / or their representatives to release any and all information pertaining to my healthcare, results, procedures, billing, and/or accounting information to the following person(s) or agencies:

	Myself		Insurance		Spouse _____
	Parent _____		Other (specify) _____		To No One

I further authorize the providers and their representative(s) to release results of my medical exams in one or more of the following ways:

May call me (patient):	
	At Home
	At Work

May leave a message:	
	At Home
	At Work

I understand that this office will release any information to those persons who I have determined may receive this information without separate consent. I also understand that this relates to all medical and billing/account information. THIS WILL BE ACTIVELY ENFORCED. If you wish to change the status of this form, you must do so in writing.

_____ _____

Patient's Signature Date

NOTICE OF DEEMED CONSENT
HIV BLOOD TESTING

A law passed in the state of Virginia allows us to test for HIV (human immunodeficiency virus) whenever any of our health care providers are exposed to a patient's bodily fluids. Bodily fluids include blood, semen, urine, feces, respiratory and sinus fluids, including, droplets, sputum, saliva, mucous, and any other fluid through which infectious airborne or blood-borne organisms can be transmitted between persons. We are not required to obtain the patient's consent for testing under these circumstances. Should this occur, we are also allowed to release the test results to the health care provider who may have been exposed.

In other words, a healthcare provider can obtain an HIV test from you and get the results if they have been exposed to your bodily fluids. However, you would be informed before any of your blood would be tested for HIV antibodies, the testing would be explained to you and you would be given the opportunity to ask any questions you may have.

I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing".

_____ _____

Patient's Signature Date

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
X Y ☐ N	*EXAMPLE: BREAST CANCER*	*45*	——	—	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐ Y ☐ N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome* *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome* *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

Adler GYN
Minimally Invasive Surgery

Recent Office Updates

FOR YOUR CONVENIENCE

- **ANNUAL VISITS ONLY COVER A BREAST AND PELVIC EXAM –**
  Other issues such as heavy bleeding, pelvic pain, hormones ect. must be addressed in another appointment. If discussed, the co-insurance is the responsibility of the patient to be paid.

  _____
  Initial above

  - MEDICAID PLAN FIRST ONLY PAYS FOR FAMILY PLANNING VISITS
  - DR. ADLER NO LONGER PRACTICES OBSTETRICS (NO BABIES)

- IF THERE HAS BEEN A **CHANGE** OF ADDRESS, TELEPHONE NUMBER, OR INSURANCE ETC. **PLEASE INFORM RECEPTIONIST AS SOON AS POSSIBLE**
- THIS IS OUR **ONLY** LOCATION. WE ARE OPEN **MONDAY - THURSDAY** FROM 7:30- 5:00 PM
- WE ARE CLOSED FOR **LUNCH** BETWEEN **12:00-1:00PM** (Phones are qued to shut off)
- WE ACCEPT ALL INSURANCES **EXCEPT** KAISER PERMANENTE
- IF YOU HAVE A BALANCE, YOU WILL **NOT** BE SEEN OR SCHEDULED AN APPOINTMENT UNTIL THE BALANCE IS PAID. FINANCE CHARGES WILL BE APPLIED
- IF BALANCE IS NOT PAID, IT WILL BE SENT TO **COLLECTIONS** AND YOU WILL BE CHARGED AN **ADDITIONAL 33.33% OF BILL ON TOP OF YOUR CURRENT BILL**
- **NO SHOW APPOINTMENTS WILL BE CHARGED A $50 FEE. Please call within 48 hours to cancel or reschedule your appointment.**

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE RECEIVED THESE UPDATES

PATIENT SIGNATURE_____ DATE _____

*IF YOU WOULD LIKE A COPY FEEL FREE TO ASK RECEPTIONIST