Memphis Obstetrics & Gynecological Association, P.C. (MOGA/MCW/WPG/WHS)

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:______________________________ Birthdate:__________

Allergies: ____

Do you have a **LATEX Sensitivity / Allergy:** Yes: ☐ No: ☐ **Other Allergies** (circle): Iodine, X-ray dye, Eggs, Peanuts

MEDICATIONS: Please list ALL medications that you take, the strength, and how often you take them

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

PHARMACY (Name and Number): ________________________________

OTHER HEALTH CARE PROVIDERS YOU CURRENTLY SEE (other than MOGA)

Provider Name	Specialty (ie: PCP, Cardio)	Phone Number:

IMMUNIZATIONS: Please check if you have received these adult immunizations and indicate when

☐ Influenza (Flu) / Date:	☐ Tetanus / Date:
☐ Pneumonia / Date:	☐ Tdap (Tetanus, Diptheria & Pertussis)/ Date:
☐ HPV Vaccine/Gardasil (Series of 3 shots – Initial shot, 2 months later, then 6 months from 1st shot) Dates (Approx. date is ok): #1 ________ #2 ________ #3 ________	

FAMILY HISTORY: Check illnesses of your **IMMEDIATE BLOOD RELATIVES** and **LIST THE RELATION**

☐ Adopted: Family history unknown	☐ Hypertension/ High blood pressure / relation:
☐ Blood clotting disorder / relation:	Malignant neoplastic disease/Cancer: (please list relative)
☐ Cerebrovascular accident (CVA) / Stroke	☐ Breast: ________ ☐ Uterine: ________
☐ Cystic fibrosis / relation:	☐ Colon: ________ ☐ Other: ________
☐ Diabetes /relation:	☐ Ovarian: ________
☐ Disorder of thyroid/ relation:	☐ Myocardial Infarction (heart attack)
☐ Heart disease / relation:	☐ Substance abuse:
☐ Hypercholesterolemia / relation:	☐ Other Family History:

SOCIAL HISTORY: Provide the following information about **YOURSELF**

Tobacco or Cigarette Use: ☐ Never Smoked ☐ Former Smoker - Date Quit ________ ☐ Current Smoker - # per day ____ # of years_____	Do you use recreational drugs? ☐ Yes ☐No If yes, which one(s) and how often? ____________
Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual
Lives ☐ alone or ☐ with others	Are you currently in a situation or relationship that makes you feel unsafe or threatened? ☐Yes ☐No If yes, explain ____________
Education (highest grade completed): ________	
Occupation: ____________	Do you refuse blood products or medical treatment of Any kind because of religious beliefs? ☐ Yes ☐ No Explain:____________
Work Status: ☐Part-time ☐Full-time ☐Retired ☐Unemployed ☐Disabled	
Do you drink alcoholic beverages? ☐ Yes ☐ No	Do you have an advanced directive: ☐ Yes ☐ No
If yes, how much? ____________	Other: ____________

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CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:______________________________ Birthdate:__________

SURGICAL HISTORY: Please list surgeries or procedures and **provide dates**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

GYN History:

Birth control method: ____________	□ Infertility
Are you sexually active? □ Yes □ No	□ Polycystic Ovarian Syndrome
If no, have you ever been sexually active? □ Yes □ No	Age of Menopause _______
Age of first sexual activity: ________	Postmenopausal Bleeding? □ Yes □ No
Number of sexual partners in lifetime: _____	Taking hormone replacement therapy? □ Yes □ No
Menses: (**only complete if still having periods**)	Have you ever had any of the following infections?
Age of first period _______	□ Chlamydia □ Gonorrhea □ Herpes □ HIV □ Syphilis
□ Regular (21-35 days apart) □ Irregular	Abnormal Pap Smear: □ Yes - date: _______ □ No
Duration of menses: ______ days	□ Colposcopy/Biopsy of cervix Date: ________
Menstrual Flow: □Mild □Moderate □Severe	□ Cryo/Date:________
	□ LEEP/Date: ________ □ CKC/Date: ________

Last **Pap Smear:** Date:__________ Provider: ____________________

Last **Mammogram:** Date: __________ Facility: ______________________________

Last **Complete Physical Exam with Primary MD:** Date: __________ Provider Name: ____________________

Last **DEXA Scan (Bone Density):** Date: __________ Facility: ______________________________

Last **Colonoscopy:** Date: __________ Provider Name: ______________________________

OB History: (Please list details of each pregnancy below)

Total Pregnancies: ___ Full term: ___ Preterm: ___ Elective abortions: ___ Miscarriages: ___ Ectopics: ___ Multiple births ___ Living ___

Date	Weeks Delivered	Birth wt	Sex	Type of Delivery & Anesthesia	Preterm Labor or Other Complications

PAST MEDICAL HISTORY: Please check illnesses or conditions YOU have had.

□ Autoimmune Disorder	**Heart Disease:** □Atrial Fibrillation □Congestive Heart Failure □CAD □High Cholesterol □High Blood Pressure (HTN)
Blood disorders: □ Anemia □ DVT (Blood Clot in leg) □ PE (clot in lung) □ Blood Transfusion: Date(s): ____________ Sickle Cell : □ Trait □ Disease	**Kidney Disease:** □ Kidney Stones □ Other__________
	Lung Disease: □Asthma □COPD □Pneumonia Do you use a CPAP machine for sleep apnea? □ Yes
□ Breast Problems (specify) ____________	
Cancer: □Breast □Ovarian □Uterine □Colon □ Other Cancer(specify) ____________	**Musculoskeletal:** Arthritis: □ Osteoarthritis □ Rheumatoid Arthritis □ Osteopenia □ Osteoporosis □ Other __________
□ Diabetes □ Gestational diabetes (in pregnancy)	
□ Eating Disorder	**Neurological:** □ Migraine Headaches □ Seizure Disorder/Epilepsy □ Stroke
Gastrointestinal Disorders: □ Acid Reflux/ GERD □ Celiac Disease □ Cirrhosis □ Crohn's Disease □ Diverticulitis □ Hepatitis/Liver Disease □ Irritable Bowel □ Ulcerative Colitis □ Other (specify): ____________	**Psychological:** □Anxiety □Bipolar □Depression □ADD
	Thyroid Disorder: □Goiter □Underactive □Overactive
	Varicella/Chicken Pox: □ Had Virus **or** □ Had Vaccine

Patient Signature: ______________________________ Date:__________

HIPAA Privacy and Release of Information Authorization

I, ' hereby authorize Memphis Obstetrics & Gynecological Association, P.C. and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice to the practice. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority and the right to exchange immunization data with my state immunization registry.
If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient Printed Name Date

Patient Signature

Women's Health Specialists
A Division of Memphis Obstetrics & Gynecological Association, P.C.
7800 Wolf Trail Cove
Germantown, TN 38138
Phone: 901.682.9222/Fax: 901.682.9505

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections MUST be completed.)

Patient:_______________________________ Birth Date: _______________

Address:_______________________________ Phone: ( ) _______________

_______________________________ SS#: _______________

Release From: _______________________ Release To: _______________________

_______________________ _______________________

_______________________ _______________________

Specific type of information to be released: [ ] any/all records [ ] Diagnostic reports [ ] Lab results [ ] Chart notes [ ] Consultation notes [ ] Operative notes [ ] Other_______________ for date range: _______________to:_______________

(if no time period specified, record from previous 5 years only will be released)

Purpose of disclosure: [ ] Transfer of Care – Reason:_______________________
[ ] Disability [ ] Worker's Comp [ ] Social Security [ ] Insurance
[ ] Attorney Request [ ] Other:_______________________

There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages.

I understand that my medical records may contain information related to **communicable diseases and infection information** as defined by statute and **Department of Public Health Rules** (which include venereal disease "VD," tuberculosis "TB," Hepatitis (any form), Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS" and AIDS Related Complex "ARC;" **alcohol and/or drug abuse treatment information** protected under regulations in 42 Code of Federal Regulations, Part 2; and **mental health treatment records, psychological services** and/or **Social Services** information including communications made to or by a social worker, psychologist or psychiatrist.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I may contact the Privacy Office at the disclosure location.

_______________________________ _______________________
Signature of Patient or Legal Representative Date

____
If Signed by Legal Representative, Relationship to Patient

Memphis Obstetrics & Gynecological Association, P.C.

Privacy Management - Protected Health Information & Communications

Protected Health Information:

I hereby authorize release of my protected health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to persons I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies. This authorization will remain in effect until revoked by the patient.

Name of authorized person	Relationship	Phone number
1.		
2.		
3.		
4.		
5.		

Patient Communications /Automated Messages:

Our practice utilizes an electronic medical records system with an integrated Patient Portal which allows patients, providers & practice staff to communicate more securely and efficiently.

Please indicate your automated messaging preference(s), one you will be sure to see, for each of the following items:

Health Notifications: When Lab results and health reminders are available on the Patient Portal you will be notified via the method you choose. Which notification method do you prefer?

☐ Email ☐ Phone ☐ Text message

Appointment Reminders: Reminders about scheduled appointments and/or appointments needing to be scheduled.

☐ Email ☐ Phone ☐ Text message

Announcements: Notifies you of an appointment cancellation/reschedule, office closure or delayed opening and other important office announcements.

☐ Email ☐ Phone ☐ Text message

Billing: Notification of new Billing Statements & outstanding balances. Statements and outstanding balances can be viewed and paid on the Patient Portal at any time.

☐ Email ☐ Phone ☐ Text message

These notification preferences only apply to **automated messages** from our office. Our office may still contact you via phone if an urgent matter requires your attention.

Patient Signature: ______________________________ Date: ______________

Printed Name: ____

Memphis Obstetrics & Gynecological Association, P.C.

IOB Prenatal History

Name:________________	Last Menstrual Period: ____________ MRN #______________
Physician: ________________	Allergies:________________
Newborn MD:________________	Current Medications:________________
Transfer OB patient? ________________	Preferred Hospital for Delivery:________________

Information for Father of baby

Father of baby: DOB:	What Insurance will your baby be covered under?
Phone/ Cell # S.S #	If baby is a Boy, do you want him circumcised?
Father of baby Insurance:	
Policy # Group #	
Insurance address: Ins Phone #	

GENETICS SCREENING and INFECTION HISTORY

	Yes	No		Yes	No
Will you be 35 years or older at time of delivery			Recurrent Pregnancy Loss (>3), or a Stillbirth		
Thalassemia (Italian, Greek, Mediterranean, or Asian)			Medications (including Supplements, Vitamins, Herbs, OTC drugs)		
Neural Tube Defect (meningomyelocele, Spina Bifida or Anèncephaly)			Illicit/Recreational Drugs or Alcohol		
Congenital Heart Defect			If yes, agents & strength/dose		
Downs Syndrome/ Other inherited genetic/ chromosomal disorder			Lives with someone with TB or exposed to TB		
Tay-Sachs (Jewish, Cajun, French Canadian)			Patient or partner has history of Genital Herpes (HSV)		
Sickle Cell Disease or Trait			Rash or Viral illness since last menstrual period		
Hemophilia			Positive Group B Strep with previous pregnancy		
Muscular Dystrophy			History of STD, GC, Chlamydia, HPV, Syphilis		
Cystic Fibrosis			History of HIV		
Huntington's Chorea			History of Hepatitis		
Intellectual Disability/Autism			Other Infection History		
If yes was fragile X tested?			History of Chicken Pox or vaccine- Which one?		
Other Inherited Genetic or Chromosomal Disorder			Hemoglobinopathy or Carrier		
Maternal Metabolic Disorder (e.g. Type 1 Diabetes, PKU)			Other Structural Birth Defect		
Patient or baby's father had a child with birth defect not listed			Recent travel history outside of country?		

Although we are advocates of natural labor and will support you if this is your plan, we are not proponents of "The Bradley Method." We believe very strongly in doing what is in the best interest of both mother & baby, and therefore cannot adhere to the unusual expectations set forth by Bradley courses you may have attended.

The American College of Obstetrics and Gynecology (ACOG) and the State of Tennessee recommend Screening HIV (AIDS) testing be performed on all pregnant women as part of their prenatal lab work, as treatment is now available to newborns with the HIV virus. This testing is performed in the beginning of your pregnancy, and during the third trimester. It is our policy to follow these guidelines.

The physicians of each division of Memphis Obstetrics & Gynecological Association appreciate you entrusting them with your medical care and hope to make your pregnancy experience as comfortable and convenient as possible.