Welcome to OB/GYN Associates!

Please arrive 15 minutes early and bring your insurance card(s), copayment and photo ID. Enclosed are the forms we need completed to make your check-in process more efficient. Please complete the forms and return them to our office **PRIOR** to your appointment date. You may fax them (515-334-7382) or return them by email to transcription@obgyndm.com. If you do not have access to either fax or email, please bring the completed forms with you to your appointment and arrive 15 minutes early.

If you need to reschedule or cancel your appointment please contact our office atleast 24 hours in advance.

Please call our office at (515) 288-3287 if you have any questions regarding your upcoming appointment.

Confidential Alternative Communications Form

Patient Name:________________________________ **Date of Birth:** _______________

(Please Print)

Please list the numbers we may use to contact you:

☐ I give my permission to leave a message/results on an answering machine. (*medical information will not be left on an unidentified answering machine*)

Home Phone: ____________________________

Cell Phone: ____________________________

Work Phone: ____________________________

Emergency Contact:

Name	Phone	Relationship

Release of Information:

Any information regarding appointment dates, times or financial information on my account may be given to:

Name	Phone	Relationship

Any medical information may be given to:

Name	Phone	Relationship

I prefer **<u>no information</u>** be given to anyone other than me __________ (initial)

<u>This form of communication will be used until revoked in writing by the patient, by expiration date below, or we have an updated form on file. Patient must initial below for the form to be valid.</u>

Patient Signature:__________________________________Date: _______________

Relationship if not patient: ________________________________

Effective Date:________________Expire Date:_______________**Patient Initials**: ______

Name:____ Date:____/____/____

Visit reason: ☐ Routine ☐ Problem (please describe):____

1. PAST MEDICAL HISTORY and other hospitalizations – Have you had the following:

Date/Explain:

- ☐ ADD/ADHD____________________
- ☐ Anemia (Type?)________________
- ☐ Anxiety disorder_______________
- ☐ Arthritis (Type?)_______________
- ☐ Asthma/breathing disorder______
- ☐ Bleeding disorder______________
- ☐ Blood transfusion (why?)_________
- ☐ Blood in urine_________________
- ☐ Bipolar______________________
- ☐ Breast disease________________
- ☐ Cancer (Type?)________________
- ☐ Depression___________________
- ☐ Diabetes (1, 2, gestational?)_________

Date/Explain:

- ☐ Fibroids______________________
- ☐ Fracture (Type?)_______________
- ☐ GI: Ulcer or IBS_______________
- ☐ Heart Disease_________________
- ☐ Heart murmur_________________
- ☐ Hepatitis (Type?)______________
- ☐ High Blood Pressure____________
- ☐ High Cholesterol ______________
- ☐ Incontinence (Type?)___________
- ☐ Kidney Stones_________________
- ☐ Lupus_______________________
- ☐ Migraines. Auras? Yes or No
- ☐ Osteopenia___________________

Date/Explain:

- ☐ Osteoporosis__________________
- ☐ Ovarian Cyst__________________
- ☐ PCOS (Polycystic Ovarian Syndrome)_____________________
- ☐ Pre-eclampsia_________________
- ☐ Seizures or Epilepsy____________
- ☐ Sexually Transmitted Diseases
  ➔ (Please circle type below)
- ☐ Stroke______________________
- ☐ Thyroid disease (Type?)_______________________
- ☐ Tuberculosis (TB)_____________
- ☐ Urinary Tract Infection__________
- ☐ Other:______________________

Please circle all that apply: Chlamydia Cold sores Genital Herpes Genital Warts Gonorrhea HIV HPV Syphilis Trichomonas

2. MONTH AND YEAR OF LAST TEST or IMMUNIZATION:

Pap Smear Never/Normal/Abnormal.	➔ If abnormal pap (most recent or ever)- complete below
Did you have a colposcopy? ☐ **No** ☐ **Yes, Approx date:** _______	*Did you have a LEEP?* ☐ **No** ☐ **Yes, Approx date:** _____________
Mammogram: Never/Normal/Abnormal	Colonoscopy: Never/Normal/Abnormal
Bone Density: Never/Normal/Abnormal	Cholesterol: Never/Normal/Abnormal
HPV/Gardasil vaccine: ☐ **No** ☐ **Yes, Approx date:** ________	Chickenpox: ☐ **No** ☐ **Yes** ➔ Chickenpox Vaccine: ☐ **No** ☐ **Yes**

3. DATE OF SURGERIES LISTED BELOW: ☐ **I have never had surgery**

Surgery and reason:	Date:	Surgery and reason:	Date:

4. CURRENT MEDICATIONS (include over-the-counter drugs, herbs, supplements): ☐ **I take no Medications**

Medication and dosage:	Physician:	Medication and dosage:	Physician:

5. ALLERGIES TO MEDICATIONS/SUBSTANCES (Latex gloves, etc.) ☐ **I have no allergies**

List:__________________________________ Reaction: __________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

6. PREGNANCIES- please include abortions/miscarriages/ectopics in both sections: ☐ **I have never been pregnant**

	Number:		Number:
Total # of Pregnancies:		Full-Term Births:	
Premature Births:		Elective Abortions:	
Miscarriages:		Living Children:	
Ectopic Pregnancies:			

No.	Date: (MM/DD/YY)	Wks Gest	Labor (hrs)	Baby's Weight/sex		Vaginal/ Vacuum/ Forceps/ C-section	Epidural	Early Labor?	Wt gain	Comments/ Complications	Location
1.					M F		☐ No ☐ Yes				
2.					M F		☐ No ☐ Yes				
3.					M F		☐ No ☐ Yes				
4.					M F		☐ No ☐ Yes				
5.					M F		☐ No ☐ Yes				
6.					M F		☐ No ☐ Yes				

(Please list additional pregnancies on the back of packet, if needed)

7. GYNECOLOGY HISTORY:

What do you or your partner currently use for birth control?			
☐ Nothing	☐ Condoms	☐ Depo Provera	☐ Vaginal Ring
☐ Birth Control Patch	☐ Diaphragm	☐ Withdrawal	☐ Vasectomy
☐ Natural Family Plan/Rhythm method	☐ Contraceptive Foam/Jelly	☐ Nexplanon: Date inserted:	☐ IUD/Type: Date inserted:
☐ Tubal Ligation	☐ Birth Control Pill ➔	Name of Pill:	

What age did you have your very first period?		Average number of days between your periods?	
How long does your period flow last?		**First day of your last period?**	
Painful periods? ☐ No ☐ Yes	Blood clots? ☐ No ☐ Yes	Period flow: ☐ Light ☐ Normal ☐ Heavy	
# of pads per day?	# of tampons per day?	Do you have spotting in between periods? ☐ No ☐ Yes	
Have you gone through Menopause? ☐ **No** ☐ **Yes**		At what age?	On Hormone Replacement Therapy? ☐ No ☐ Yes

8. SOCIAL HISTORY- Please list habits below:

Caffeine? ☐ **No** ☐ **Yes** - ☐ Current ☐ Former ➔	Drinks per day:	Drinks per week:
Alcohol? **No** **Yes** - Current Former ➔	Drinks per day:	Drinks per week:
Smoking? ☐ **No** ☐ **Yes** - ☐ Current ☐ Former ➔	Packs per day:	Number of years:
Vaping? ☐ **No** ☐ **Yes** - ☐ Current ☐ Former ➔	Amount per day: ☐	Number of years: ☐ ☐
Drug Use? **No** **Yes** - Current Former ➔	Frequency:	Marijuana Meth Cocaine Heroin Opioids
☐ Highest level of education completed: ☐ Middle School GED High School Some College Trade/Tech school Associate Degree Bachelor's Degree Master's Degree PhD, MD, Law, Other advanced graduate degree ☐ ________		
What is your occupation?	Do you use seat belts? **No** **Yes**	
Do you Exercise? ☐ **No** ☐ **Yes** ➔ How much? ☐ Once a week or less ☐ 1-3 times a week 4 or more times weekly		
History of abuse? **No** **Yes** ➔ Physical Emotional Sexual ➔	Do you feel safe now? **No** **Yes**	
Marital Status: Single ☐ ☐ Married Divorced Engaged ☐ Widowed ☐ Separated		
Are you sexually active? **No** **Yes** **Never** ➔ Do you have sex with **Male** **Female** **Both**		
What gender do you identify with? Male Female Other:		

9. FAMILY HISTORY- check if your blood relatives have had: ☐ **I am adopted and unsure of history**

MAJOR ILLNESSES:	None	Mom	Dad	Brother	Sister	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)	Uncle	Aunt
Diabetes:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects: *Please specify below:*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER: *Please specifiy below:*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

10. FAMILY CANCER HISTORY- Please include age of diagnosis: ☐ **I am adopted and unsure of history**

EXAMPLE:	**Breast**	**Ovarian**	**Colon**	**Uterine**	**Prostate**	**Pancreas**	**Gastric**	**Skin**
Maternal aunt:		65						
Maternal Grandmother:	49							

	Breast	**Ovarian**	**Colon**	**Uterine**	**Prostate**	**Pancreas**	**Gastric**	**Skin**
Self:								
Sister(s):								
Brother(s):								
Mother:								
Father:								
Son(s)/Daughter(s):								

Mother's side								
Maternal Aunt(s):								
Maternal Uncle(s):								
Maternal Grandmother:								
Maternal Grandfather:								
Cousin(s)/Others:								

Father's Side								
Paternal Aunt(s):								
Paternal Uncle(s):								
Paternal Grandmother:								
Paternal Grandfather:								
Cousin(s)/Others:								

HEREDITARY **RISK ASSESSMENT** FORM

Patient's Name: ______________________

Today's Date: ________________________

Date of Birth: ________________________

Have you and/or a close blood relative (father, mother, brother, sister, child, uncle, aunt, grandfather, grandmother, nephew, niece) had any of the following:

PLEASE CIRCLE Y or N BELOW FOR ALL THAT APPLY:

Cancer Family History			SELF	Which relative(s) was diagnosed with cancer?		Age at Diagnosis
				Mother's Side	Father's Side	
y	N	Breast cancer diagnosed BEFORE AGE 50 and/or Breast cancer in SELF AT ANY AGE				
y	N	3 Breast cancers on the same side of the family AT ANY AGE				
y	N	Ovarian or Pancreatic cancer diagnosed AT ANY AGE				
y	N	1 Colon and/or Uterine cancer diagnosed BEFORE AGE 50?				
y	N	3 or more Colon and/or Uterine cancers on the same side of the family AT ANY AGE				

Please circle any other cancers in the family: PROSTATE **MELANOMA** **GASTRIC** Age at Diagnosis.__________________

y	N	Ag planning to become pregnant in the future?
y	N	Have you had genetic carrier screening? (Cystic Fibrosis, **SMA,** Fragile X)

Patient Signature:________________________________Which Provider are you seeing today?_________________________Insurance Plan: ____________________________

PLEASE SEE **REVERSE** SIDE

Please complete if you are FEMALE and NEVER had breast cancer

- Your current height (ft/in)___________Your current weight (lbs)____ _
- Your menopausal status; please circle
  - Pre-menopausal
  - Peri- menopausal (time before menopause marked by irregular cycles)
  - Post- menopausal: Age of onset ___ _
  - (permanent cessation of period for 12 months or longer)
- Your age at time of first menstrual period ___ _
- Your age at time of first live birth____ _
- Did you ever use Hormone Replacement Therapy? Yes No
- If yes, type: Combined Estrogen only Progesterone only Unknown
- If yes, are you a: Current user: How many years ago did you start?____ _
  - Intend to use for___________more years
- Past user: How many years ago did you stop using?____ _
- Have you ever had a breast biopsy? Yes No
- If yes, do you know your diagnosis?______________________
- Number of daughters___________Number of sisters____ _
- Number of maternal aunts (mother's sisters)____ _
- Number of paternal aunts (father's sisters)____ _

- 1 family member with ovarian or pancreatic cancer at any age (rare)
- 1 family member with cancer dx at 49 or younger (young)
- 3 family members (same side) dx at any ages (multiples)
- Patient dx with breast cancer at any age
- Triple Negative Breast Cancer (TNBC) dx under 60
- Male breast cancer (rare)
- Ashkenazi Jewish descent (1 in 40 carry mutation)

Please email completed form to transcription@obgyndm.com