

OBSTETRICAL &
GYNECOLOGICAL
associates p.l.c.

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 Attn: Kelsey or Kristen) 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 at least 24 hours in advance.

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



Authorization and Consent for Treatment

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: _____

Address: _____

City, State, Zip: _____

Email: _____

Due to certain testing that may be done, we will need race and ethnicity information.

Please select your race and ethnicity:

Race:

- African American/Black
- American Indian/Alaskan Native
- Asian
- Pacific Islander
- White/Caucasian
- Other: (Specify) _____
- Decline to report

Ethnicity:

- Not Hispanic or Latino
- Hispanic or Latino
- Decline to Report

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Spouse Name: _____ Spouse DOB: _____

Insurance Policy Holder/Relationship: _____ Policy Holder DOB: _____

Do you have Iowa Medicaid/Amerigroup/Iowa Total Care insurance? Yes _____ No _____

Does your insurance require a specific lab? Yes _____ No _____ If so, which lab is required? _____

(We send lab specimens to Mercy unless you request otherwise.)

I request and authorize health care services by my provider as he/she deems advisable and in my best interest. This may include routine diagnostic, radiology and laboratory procedures as well as medication administration and drug screening during pregnancy. I authorize OBGYN Associates of Des Moines PLC to release my immunization information to the state registry. I also agree that OBGYN Associates of Des Moines PLC can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

I hereby authorize the release of any information acquired in the course of my examination or treatment for the processing of an insurance claim. I also request that payment of authorized Medicare benefits and any other insurance benefits be made to OB/GYN Associates of Des Moines, PLC for any services provided to me by them.

By signing this consent form, I agree to pay OB/GYN Associates of Des Moines, PLC for any co-insurance, co-payments, deductibles or other amount not paid for by insurance. Failure to do so may result in collection action or denial of future treatment. I understand that OBGYN Associates will charge a \$50 fee per visit for any no show or same day cancel without a 24 hour notice. I acknowledge OBGYN Associates has a discharge policy after three no shows.

Signature: _____ Date: _____

Relationship to Patient (if applicable): _____

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 **no information** be given to anyone other than me _____ (initial)

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.

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:

<input type="checkbox"/> ADD/ADHD _____ <input type="checkbox"/> Anemia (Type?) _____ <input type="checkbox"/> Anxiety disorder _____ <input type="checkbox"/> Arthritis (Type?) _____ <input type="checkbox"/> Asthma/breathing disorder _____ <input type="checkbox"/> Bleeding disorder _____ <input type="checkbox"/> Blood transfusion (why?) _____ <input type="checkbox"/> Blood in urine _____ <input type="checkbox"/> Bipolar _____ <input type="checkbox"/> Breast disease _____ <input type="checkbox"/> Cancer (Type?) _____ <input type="checkbox"/> Depression _____ <input type="checkbox"/> Diabetes (1, 2, gestational?) _____	<p style="text-align: center;">Date/Explain:</p> <input type="checkbox"/> Fibroids _____ <input type="checkbox"/> Fracture (Type?) _____ <input type="checkbox"/> GI: Ulcer or IBS _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Heart murmur _____ <input type="checkbox"/> Hepatitis (Type?) _____ <input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> High Cholesterol _____ <input type="checkbox"/> Incontinence (Type?) _____ <input type="checkbox"/> Kidney Stones _____ <input type="checkbox"/> Lupus _____ <input type="checkbox"/> Migraines. Auras? Yes or No _____ <input type="checkbox"/> Osteopenia _____	<p style="text-align: center;">Date/Explain:</p> <input type="checkbox"/> Osteoporosis _____ <input type="checkbox"/> Ovarian Cyst _____ <input type="checkbox"/> PCOS (Polycystic Ovarian Syndrome) _____ <input type="checkbox"/> Pre-eclampsia _____ <input type="checkbox"/> Seizures or Epilepsy _____ <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> → (Please circle type below) <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Thyroid disease (Type?) _____ <input type="checkbox"/> Tuberculosis (TB) _____ <input type="checkbox"/> Urinary Tract Infection _____ <input type="checkbox"/> Other: _____
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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?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Approx date: _____	Did you have a LEEP? <input type="checkbox"/> No <input type="checkbox"/> Yes, Approx date: _____
Mammogram:	Never/Normal/Abnormal	Colonoscopy: Never/Normal/Abnormal
Bone Density:	Never/Normal/Abnormal	Cholesterol: Never/Normal/Abnormal
HPV/Gardasil vaccine:	<input type="checkbox"/> No <input type="checkbox"/> Yes, Approx date: _____	Chickenpox: <input type="checkbox"/> No <input type="checkbox"/> Yes → Chickenpox Vaccine: <input type="checkbox"/> No <input type="checkbox"/> 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		<input type="checkbox"/> No <input type="checkbox"/> Yes				
2.				M F		<input type="checkbox"/> No <input type="checkbox"/> Yes				
3.				M F		<input type="checkbox"/> No <input type="checkbox"/> Yes				
4.				M F		<input type="checkbox"/> No <input type="checkbox"/> Yes				
5.				M F		<input type="checkbox"/> No <input type="checkbox"/> Yes				
6.				M F		<input type="checkbox"/> No <input type="checkbox"/> Yes				

7. GYNECOLOGY HISTORY:

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

What do you or your partner currently use for birth control?			
<input type="checkbox"/> Nothing	<input type="checkbox"/> Condoms	<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Vaginal Ring
<input type="checkbox"/> Birth Control Patch	<input type="checkbox"/> Diaphragm	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Natural Family Plan/Rhythm method	<input type="checkbox"/> Contraceptive Foam/Jelly	<input type="checkbox"/> Nexplanon: Date inserted:	<input type="checkbox"/> IUD/Type: Date inserted:
<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	Blood clots? <input type="checkbox"/> No <input type="checkbox"/> Yes	Period flow: <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy	
# of pads per day?	# of tampons per day?	Do you have spotting in between periods? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you gone through Menopause? <input type="checkbox"/> No <input type="checkbox"/> Yes	At what age?	On Hormone Replacement Therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes	

8. SOCIAL HISTORY- Please list habits below:

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

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	Are you 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