MOUNTAINSTAR Healthcare

Lakeview OB / GYN
Gynecology and Women's Healthcare

Name: _____ Age: _____ DOB: _____
(First) (Last) (Maiden)
Reason for today's visit: _____ Today's Date: _____
How did you hear about us? Referred by: _____ Email: _____

Gynecology History

First day of your last period? _____ Last pap smear? _____
How often do you have your period? _____ Any *abnormal* paps? _____
How many days to they last? _____ Last mammogram? _____
Are your periods painful? _____ Last bone density scan? _____
Age at first period? _____ Last cholesterol test? _____
What do you use for birth control? _____ Last colonoscopy? _____
Are you currently sexually active? Yes _____ No _____ Have you gone through menopause? _____
Any history of sexually transmitted infections? _____

Pregnancy History

How many times have you been pregnant? _____ How many live births? _____
How many miscarriages? _____ How many abortions? _____
Have you had any C-sections? Yes_____ No_____ If yes, how many? _____

Medical History

Are you allergic to any medications? Yes_____ No_____ If yes, please list: _____
Do you have any of the following conditions?

Cancer:_____	Heart disease:_____	High blood pressure:_____
Asthma:_____	Bowel disorder:_____	Stomach/ulcer disease:_____
Diabetes:_____	Thyroid problems:_____	Kidney/urinary disease:_____
Hepatitis:_____	Blood clots, leg/lungs:_____	Seizure/neurological disorder:_____

Other medical problems:_____

Current Medications/Supplements/Vitamins

Name and dosage (Please continue on the back of page, if needed)

_____ _____
_____ _____

Social History

Any alcohol use? Yes___ No___ If yes, how many per occasion? _____
Any tobacco use? Yes___ No___ If yes, how many per occasion? _____
Any caffeine use? Yes___ No___ If yes, how many per occasion? _____
Any drug use? Yes___ No___ If yes, how many per occasion? _____
Any history of domestic/sexual violence? Yes___ No____

Surgical history

Year and type of surgery (Please continue on the back of page, if needed)

_____ _____

Recent hospitalizations

_____ _____

Family history (Any family member)

Breast cancer:_____ Cervical cancer:_____ Ovarian cancer:_____ Uterine cancer:_____
Colon cancer:_____ Other medical problems that run in the family:_____

Preferred pharmacy

Preferred Lab

Lab:_____ I understand that I am responsible for providing the name of the laboratory my insurance required I use. Lakeview OB/GYN defaults to MSCL/PAML

GENERAL CONSENT FOR CARE AND TREATEMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us the permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risk and benefit of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and or mid-level provider (nurse practitioner, physician assistant, or clinic nurse specialist), and other health care providers or the designees care at this practice. I understand that if additional testing, invasive or interventional procedures are recommend. I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____ Date:_____

Printed name of patient or personal representative:_____ Relation to patient:_____