Established Patient Interval History Update Form

Patient Name:_____ Emergency Contact:_____

Current Tobacco Use: Yes□ No
How much alcohol do you drink? □ P/day_____ P/week_____ P/month_____
Do you exercise? □ Yes □No What type of exercise?_____ Times/week:_____
Marital Status:(circle one) Single Married Divorced Widowed

Who is your Primary Care Physician?_____
Other treating Physicians: _____ For:_____
_____ For:_____

Date last menstrual period started_____ or Menopausal Since:_____
Do you experience cramps? □ None □Mild □Moderate □ Severe (circle one)
Does your menstrual cycle occur once a month? Yes No
How many days do you normally bleed _____ Mild Moderate Heavy (circle one)
How often does your menstrual cycle start? Every_____ Days or Weeks (circle one)

Are you trying to conceive? Yes No
Are you using contraception? Yes No
What method (s) of contraception are you currently using? Please circle all that apply.

Abstinence	Withdrawal	Condoms	Birth Control Pill	Patch
Rhythm	IUD	Tubal Ligation	Patch	Essure
Injectable	Vasectomy	Nuva Ring	Nexplanon	

Date of last Mammogram _____
Have you had a colonoscopy or cologuard since your last visit? □Yes □No Date:_____
Have you had a bone density since your last visit? □Yes □No Date:_____

Do you have any **NEW** medical issues since your last visit? Yes No Please check all that apply:

( ) High Blood Pressure	( ) High Cholesterol	( )Thyroid Disease
( ) Heart Disease	( ) Stroke	( ) Arthritis
( ) Heart Attack	( ) Depression / Anxiety	
( ) Psychiatric Disorder	( ) Diabetes	

List any other medical issues since your last visit _____Date:_____

Have you had any surgeries or hospitalizations since your last visit? □Yes □No
Surgery/Hospitalization:_____ Date:_____
Surgery/Hospitalization:_____ Date:_____

Have you had a tetanus or TDAP booster in the last 10 yrs? Yes No - Do you want one today? Yes No

Please list all current **medications & dosages** (Prescription, Non-Prescription, Vitamins, or Supplements including calcium or herbal supplements) If you need additional space, please use the back of this form and check here ☐
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Have you developed any allergies to medications, food, or latex since your last visit? Yes No
If Yes, Please explain _____

☐ **If there are no changes since your last visit, check this box and stop here**.

Patient Name:_____

FAMILY MEDICAL HISTORY - Please list any changes to your family medical history that you are aware of: Example diabetes, heart disease, cancer

Illness	Relative	Maternal Or Paternal side of family	Age at Diagnosis	Comments	Are they still living? Yes or No

Family History Questionnaire for **Common Hereditary Cancer Syndromes**

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Have you ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If Yes, the results were:_____
Has any member of your family ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If yes, the results were:_____
If you answered yes to either questions above, please obtain copy of relatives test results.

Breast and Ovarian Cancer	You	Age at diagnosis	Siblings/ children	Age at diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Breast Cancer (male or female)								
Ovarian Cancer								
Breast cancer in both breasts OR Multiple primary breast cancers								
Male Breast Cancer								
Pancreatic Cancer								
Prostate Cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Colon and Uterine Cancer	You	Age at diagnosis	Siblings/ Children	Age at Diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Uterine (endometrial) Cancer								
Colorectal Cancer								
10 or more cumulative colon polyps								

Plano Women's Healthcare, P.A.

Drs. Heather Bellanger, Julie DaVolio, Marlene Diaz,
Arlene Jacobs, Amy Mos, Lisa Umholtz

PATIENT RECORD OF DISCLOSURE

The HIPAA Privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information (PHT). The individual is also granted the right to request confidential communications, or that a communication be made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: **(Number the selections below in order of your preference)**

____By my **home** telephone, My number is:_____

____It is ok to leave me a message with detailed information.

____It is NOT ok to leave me a message with detailed information.

____By my **cell phone**, my number is:_____

____It is ok to leave me a message with detailed information.

____It is NOT ok to leave me a message with detailed information.

____It is ok to contact me at **work** and my number is:_____

____It is ok to leave me a message at work with detailed information.

____It is NOT ok to leave me a message at work with detailed information.

____It is ok to leave a callback number ONLY at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

____My spouse, whose name is:_____Phone_____

____My parent, whose name is:_____Phone_____

____No one other than myself

____Fill in any other name you desire:_____Phone_____

Patient or Guardian Signature:_____Date:_____

Patient Name(please print):_____Date of Birth_____

Name of legal guardian/caretaker:_____

Plano Women's Healthcare, P.A.

Obstetrics, Gynecology & Infertility

1600 Coit Road, Suite 202
Plano, Texas 75075

Telephone:
(972) 596-2470

Thank you for choosing Plano Women's Healthcare for your obstetrical and gynecological needs.

The purpose of this form is to better acquaint you with the payment policies of this office. Please present your insurance card to the receptionist upon check-in. You must present your card every time you are seen in this office. Intentional misrepresentation of your insurance coverage is grounds for dismissal from this practice. You may also be held liable for any fines or penalties assessed to this office by or on behalf of the insurance company.

Our office participates in several PPO and HMO insurance plans. Non-PPO/HMO plan patients are responsible for all amounts deemed above the usual and customary or otherwise not paid for by their insurance carrier. If we are providers on your insurance plan, contractual adjustments will be taken. It is your responsibility to verify your insurance eligibility and deductible information prior to your appointment. You will be responsible for all co-pays, co-insurance, and deductibles along with any service that is not covered on your insurance plan. Your co-pays and any applicable deductible amounts may be collected at the close of your appointment. All non-insured patients must pay for each visit in full at the time of service. Our office accepts the following forms of payment: Cash, Check, MasterCard, Visa and Discover. All account balances not paid in full within 30 days will be sent to our collection agency.

Plano Women's Healthcare carefully reviews fees every year to ensure they are representative of the Plano area and for the quality of care which we provide to our patients. It is not the responsibility of this office to dispute these differences with your insurance carrier. Please do not hesitate to contact the insurance department if you have any questions.

Letters written and forms completed at your request may be subject to a fee depending on the context and time involved in producing such letter/form. You will be notified of the fee prior to processing.

Please be aware that there will be a $25.00 fee charged to your account for all No-Shows or appointments that you fail to cancel within 24 hours prior your appointment.

We realize that you have many choices for healthcare. We appreciate the opportunity to provide you with excellent care. Thank you for choosing Plano Women's Healthcare.

I have read and understand the payment policies of Plano Women's Healthcare, P.A.

_____

Print Patient Name Date of Birth

_____

Patient Signature Date of Appointment

Please sign below indicating that you have read and all of your questions have been answered.

With the new guidelines of the Affordable Care Act (ACA), preventative health care is now covered without being subject to deductible or co-insurance. However, please be aware that preventative health care does not include the management of common counseling/illnesses such as procreative counseling, depression, hormone replacement therapy, hypertension, menstrual irregularities, infections or follow-up of abnormal lab work, just to name a few. In accordance with national guidelines and our contract with your insurance company, these illnesses are coded, billed and paid separately. Management of an illness in conjunction with your preventative visit will be applied to your deductible, co-pay and co-insurance. You have the option of discussing everything with your physician at your visit today. If this is your choice, we will bill your insurance and collect your co-pay today. We will bill you for your co-insurance and deductible accordingly.

Signature: _____Date: _____

Patient's Name:_____

		Yes	No	Comments
Constitutional	Fever	☐	☐	
	Chills	☐	☐	
	Sweats	☐	☐	
	Weight loss	☐	☐	
	Weight Gain	☐	☐	
	Fatigue	☐	☐	
Respiratory	Painful breathing	☐	☐	
	Chronic cough	☐	☐	
	Productive cough	☐	☐	
	Dry cough	☐	☐	
	Shortness of breath	☐	☐	
	Wheezing	☐	☐	
Gastrointestinal	Abdominal Pain	☐	☐	
	Change in bowel habits	☐	☐	
	Dark or bloody stool	☐	☐	
	Frequent constipation or diarrhea	☐	☐	
	Indigestion	☐	☐	
	Change in appetite	☐	☐	
	Nausea/vomiting	☐	☐	
Genitourinary	Incomplete emptying	☐	☐	
	Painful urination	☐	☐	
	Frequent urination	☐	☐	
	Urinary urgency	☐	☐	
	Blood in urine	☐	☐	
	Urinary Incontinence	☐	☐	
	Getting up at night to urinate	☐	☐	
	Bleeding or pain with intercourse	☐	☐	
	Unusual discharge or odor	☐	☐	
	Vulvar or vaginal itching or burning	☐	☐	
	Pelvic Pain	☐	☐	
Allergy/Immuno	Sneezing	☐	☐	
	Itching eyes or nose	☐	☐	
	Hives	☐	☐	
Musculoskeletal	Back Pain	☐	☐	
	Weakness	☐	☐	
	Joint pain, stiffness	☐	☐	
	Swelling of legs	☐	☐	
Eyes	Spots before eyes	☐	☐	
	Double vision	☐	☐	
Ears, Nose, Throat	Ear aches	☐	☐	
	Nose bleeds	☐	☐	
	Sore throat	☐	☐	
	Dry mouth	☐	☐	
Cardiac	Dizziness	☐	☐	
	Shortness of breath at rest	☐	☐	
	Shortness of breath w/mild exertion	☐	☐	
	Chest pain	☐	☐	
	Loss of consciousness	☐	☐	
	Palpitation	☐	☐	
Neurologic	Numbness or tingling	☐	☐	
Skin	Nodules	☐	☐	
	Change in moles, freckles	☐	☐	
	Change in hair growth, loss, texture	☐	☐	
	Breast lumps	☐	☐	
	Breast nipple discharge	☐	☐	
	Breast pain	☐	☐	
Heme/Lymph	Swollen lymph glands	☐	☐	
	Easy bruisability	☐	☐	
Endocrine	Excessive thirst	☐	☐	
	Tremor	☐	☐	
	Cold or heat intolerance	☐	☐	
	Excessive urination	☐	☐	
Psych	Depression	☐	☐	
	Anxiety	☐	☐	
	Mood Swings	☐	☐	