ACKNOWLEDGMENT AND CONSENT

I understand that Women's Care, (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:______________________________ Date:______________
(Patient)

-OR-

By:______________________________ Date:______________
(Patient representative)

Description of Representative's Authority: ______________________________

AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize ______________________________ to disclose a copy of the specific health and medical information described below regarding:

____
(Name of patient)

consisting of: ____

____

(Describe information to be used/disclosed)

to: The Fertility Center of Oregon, 590 Country Club Parkway, Ste A, Eugene, OR 97401,

for the purpose of: ____
(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Jennifer Ocker at 590 Country Club Parkway, Eugene, OR 97401 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of ______________ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:________________________________ Date:______________
(Patient)

- OR -

By:________________________________ Date:______________
(Patient representative)

Description of Representative's Authority:______________________________

THE FERTILITY CENTER OF OREGON
Women's Care
590 Country Club Pkwy, Suite A
Eugene, Oregon 97401
(541) 683-1559

GYNECOLOGY MEDICAL HISTORY

Name: ______________________ Preferred name: __________ Date of Birth: _______ Age: ___ Today's Date: ______

Primary Care Physician: _________________________ OB-GYN Physician: __________________________________

Who referred you to us for care: _____________________________

Main reason for visit (*in your own words*) ____

____

____

MEDICAL HISTORY

Current medical problems: ____

Have you ever had any serious illnesses, injuries, or hospitalizations other than listed above: ____________________

Date __________ Problem ________________________ Treatment ____

Date __________ Problem ________________________ Treatment ____

Date __________ Problem ________________________ Treatment ____

Date __________ Problem ________________________ Treatment ____

SURGERIES

Date: ___________ **Procedure:** ____

___________ ____

___________ ____

___________ ____

MEDICATIONS

Med:_____________________________ **Dose:** __________________ **Prescriber:** _________________________

_____________________________ __________________ _________________________

_____________________________ __________________ _________________________

_____________________________ __________________ _________________________

ALLERGIES

Allergy to: _______________________ **Reaction:** ____

_______________________ ____

_______________________ ____

HEALTH MAINTENANCE

Bone Density
Calcium intake: Servings of dairy daily: _______________ Calcium supplements: _________ mg.
Bone density scan date: _________ Result: ____

Exercise: _____ days per week Type ____

Are you on a weight loss plan? ______ If so, which one _______________ What is your goal weight? _______

Breast Screen: Do you perform self-breast examinations? ____ Yes ____ No

Date of last mammogram ________ Result ____

Do have a history of abnormal mammogram? ____ Yes ____ No

Labs: *(check if yes and add date if known)*

___ TSH ____________ ___ Fasting glucose _____________
___ Free T_4 __________ ___ Cholesterol panel ___________
___ Blood count _______

Colon Screen: Date of colonoscopy ______ Result: ____

Immunizations *(please check if yes and list date of last)*

___ Influenza __________
___ Tetanus __________
___ Varicella __________
___ Rubella __________
___ Pneumococcal __________
___ Hepatitis A __________
___ Hepatitis B __________
___ Zoster (shingles) __________
___ HPV (Gardasil) __________

GYNECOLOGICAL HISTORY

First day of last normal menstrual period: _______________

How old were you when your menstrual period started: ________

Have you ever had irregular cycles? ____ No ____ Yes

What is the usual number of days from the start of one period to the start of the next: __________________

How many days do you flow: _____________

Flow is usually: ___ Light ___ Moderate ___ Heavy

Do you have any discomfort during your period (menstrual cramps)?

___ Never ___ Rarely ___ Usually *(If you checked “never”, please skip to the next question)*

Onset: ____ years
Severity: ____ severe *(have to stop usual activities)*
____ moderate
____ mild
Changes: ____ getting worse
____ about the same
____ getting better
Location: ____ midline lower abdomen
____ both sides lower abdomen
____ one side of abdomen
Timing: ____ starts before flow
____ starts on first day
____ starts on subsequent day

Have you ever had any of the following: *(Check if yes)*

Bleeding, staining, or spotting between periods _____
Bleeding or spotting after intercourse ____
Heavy bleeding, gushing, large clots (blood runs down leg, requires two pads at once) _____
Recent change in periods *(Please describe)* ____

Do you have PMS symptoms which generally interfere with normal activities: ____ No ____ Yes

Describe symptoms: ____

Have you ever had a Pap smear? ___ Yes ___ No

If yes, date: ____________ Doctor: ______________________

Do you have a history of abnormal Pap smears? ____ Yes ____ No

If yes: Date _____________ Treatment ______________________________

Current method of birth control: ____

Sexual health: Is there anything you would change about your sex life? ______________________________

Have you ever had: *(check if yes and please tell us when)*

____ Chlamydia ______________________________
____ Gonorrhea (clap, GC) ______________________________
____ Infected tubes or ovaries ______________________________
____ Vaginal infections ______________________________
____ Blood in urine ______________________________
____ Burning or stinging with urination ______________________________
____ Infection of bladder or kidney ______________________________
____ Trouble starting to urinate ______________________________
____ Loss of urine with cough or sneeze ______________________________
____ Any other problems with female organs: ____________________
____

PREGNANCY

A. Have you ever been pregnant? ___ Yes ___ No *(If no, please skip to the next section)*

Fill in the number of:

____ Term deliveries (baby weighed over 5½ pounds at birth and was born at least 37 weeks of pregnancy)
____ Premature deliveries (over 5 months pregnancy but baby weighed under 5½ pounds)
____ Miscarriages (before 5 months)
____ Abortions
____ Ectopic or tubal pregnancies
____ Children now living
____ Twins or triplets

B. If you have had any TERM or PREMATURE deliveries, please fill in this section *(Attach additional pages if needed))*

1. Delivery Date ____________ Weeks of pregnancy* ________________________
   Length of labor __________ Type of anesthesia _______________ Delivery Type ________________
   Hospital ____
   Boy or girl (*circle*) Weight (pounds, ounces) _____________
   Any problems with delivery or pregnancy? ____

2. Delivery Date ____________ Weeks of pregnancy* ________________________
   Length of labor __________ Type of anesthesia _______________ Delivery Type ________________
   Hospital ____
   Boy or girl (*circle*) Weight (pounds, ounces) _____________
   Any problems with delivery or pregnancy? ____

*Your due date was 40 weeks. If you delivered one week late, write 41. If you delivered three weeks early, write 37, etc.

C. If you have had any ABORTIONS or MISCARRIAGES, fill in this section

1. Month/Year ____________ Weeks of pregnancy* _______________________
   Doctor's name ____
   Hospitalized? ______________ D&C (scrape uterus) ____________

2. Month/Year ____________ Weeks of pregnancy* _______________________
   Doctor's name ____
   Hospitalized? ______________ D&C (scrape uterus) ____________

*Weeks between last normal menstrual period and termination of pregnancy.

SOCIAL HISTORY

Occupation ______________________________ Are you satisfied with your work? ________________

Please check: ___ Single ___ Married ___ Same sex ___ Partnered ____ Widowed ___ Divorced

Partner's name: ______________________________ Years with current partner ____________

Are you happy with your partner? ____

Do you smoke tobacco? ____ No ____ Yes *(if yes, please answer the following)*

If yes, how many packs per day _____ For how many years? ______

Previous tobacco use: Start date ___________ Quit date __________ Packs per day ______

Do you use any other tobacco products? ____ No ____ Yes

Do you drink alcohol? ____ No ____ Yes *(f yes, please answer the following)*

____ oz. liquor per *(circle one)* day / week / month

____ 12 oz. glasses beer per day / week / month

____ 6 oz. glasses wine per day / week / month

Have you ever used any non-prescription drugs such as: *(if yes, please indicate when last used)*

____ Marijuana __________________________
____ LSD, STP, etc. ______________________
____ Heroin, etc. _________________________
____ Morphine, Demerol, etc. _______________
____ Barbiturates __________________________
____ Injected drug of any kind _______________

Have you ever been treated or diagnosed for anorexia or bulimia? ____ No ____ Yes

If yes, when ____

Have you ever been the victim of sexual, physical, or emotional abuse? _____________________________________

Hobbies/Activities? ____

FAMILY HISTORY

Please list any members of your family including parents, grandparents, brothers and sisters who have had significant medical problems such as high blood pressure, diabetes, heart attack, cancer:

Relationship	Medical Problem
Maternal grandmother………………..	________________________________
Maternal grandfather ………………...	________________________________
Paternal grandmother ……………….	________________________________
Paternal grandfather …………………	________________________________
Mother …………………………………	________________________________
Father …………………………………	________________________________
Siblings: Brother / Sister *(please circle)*	________________________________
Brother / Sister	________________________________
Brother / Sister	________________________________
Children ……………………………….	________________________________

Has anyone in your immediate family or among grandparents, aunts, uncles and first cousins had any of the following diseases or problems? *(check if yes)*

____ Congenital abnormalities – i.e., any defects present at birth or any disorders which "run in the family"
____ Infertility – i.e., difficulty getting pregnant for any reason
____ Delayed puberty (didn't shave; didn't menstruate or develop breasts)
____ Breast, ovarian, or endometrial cancer
____ Frequent miscarriages

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms? *(Check if yes)*:

____ Weight change
____ Fatigue
____ Change in vision
____ Difficulty swallowing
____ Chest pain
____ Racing or irregular heartbeat
____ Fainting or blackout spells
____ Shortness of breath
____ Snoring
____ Nausea
____ Constipation
____ Diarrhea
____ Vomiting
____ Urinary incontinence (leaking urine)
____ Vaginal discharge
____ Vaginal odor
____ Vaginal itching or irritation
____ Pain with intercourse
____ Irregular menstrual periods
____ Heavy menstrual periods
____ Neck or back pain
____ Muscle aches or cramps
____ Joint pain
____ Acne
____ Rash or skin lesion
____ Headaches
____ Numbness or tingling
____ Dizziness
____ Thoughts of Suicide
____ Anxiety / Excessive worrying
____ Depression
____ Feeling excessive cold or warmth
____ Unwanted hair growth
____ Discharge from nipples
____ Excessive bleeding or bruising
____ Runny nose
____ Sore throat
____ Cough
____ Pain. Location ______________________
____ Other ______________________________