Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Contents of OB Forms Packet "All OB Forms"

This packet is designed to be printed DOUBLE-SIDED. Thank you.

WELCOME TO OUR PRACTICE

In preparation for your upcoming appointment, we would like you to get a head start with some of the paperwork and also tell you a bit about our practice.

Our services include comprehensive medical care for women of all ages, such as well woman exams, contraception, routine and high-risk OB care, hormone management, menopause issues, gynecologic and laparoscopic surgery and more.

We also offer the services of Marina's Oasis, a medical aesthetic center specializing in Phototherapy, Photo Facials, Light-Sheer® Laser Hair Removal, Botox® and Juvederm® treatments, chemical peels, microdermabrasion and comprehensive skin care programs.

EMR (electronic medical record)

Our practice uses a computerized health record, called an EMR. It takes additional time to enter all of your information into the computer. **Therefore, it would be very helpful if you would complete the enclosed forms and then mail them to us before your appointment.** This will give us time to enter your medical information. If you do not send these forms, your visit could be delayed while we update the computer before you see the doctor.

Please arrive early

New patients: Please arrive a minimum of 30 minutes early for this first appointment to allow us ample time to enter or update your personal, insurance and health information. At this visit we will scan your driver's license and insurance card for entry into our EMR. *We guarantee to keep all of your personal information private.* This is the law (a Federal law called HIPPA).

We charge for a "no-show"

Please call us at least 24 hrs in advance if you are unable to keep your appointment. There is a $25 charge for a no-show appointment (waived if you make and keep the next appointment). When you do not show up or call ahead, we have lost the chance to have another patient use that appointment time.

Parking – we do not validate

Please note that you pay the cashier BEFORE returning to your car.

Lab

We have an on-site lab, called Primex. This is where all our lab tests are run except our pap smears. We send pap smears to Huntington Hospital Cytopathology. It is your responsibility to know which lab your insurance is contracted with. If your insurance requires us to use a different lab than mentioned above, you have to let us know.

Feel free to call us at any time if you have any questions. Call (626) 304-2626.
Thank you for trusting us with your medical care. We look forward to seeing you!

PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY _____ [Office use: (HH Med Rec # _____]

PATIENT LAST NAME _____ FIRST NAME_____ M.I. _____

PREFERRED NAME _____ MAIDEN NAME_____

DATE OF BIRTH _____ SSN# _____ RACE _____

MARITAL STATUS M S D W _____ DRIV LIC. # _____ RELIGION _____

ETHNICITY (H, NH or D) _____ (H - Hispanic, NH - Non-Hispanic or D- Declined)

ADDRESS _____ (PO Boxes Not Allowed)

ZIP _____ CITY _____ STATE_____

HOME PH.# _____ WORK PH.# _____ CELL PH.# _____

FAX # _____ email: _____

PREFERRED PHONE NUMBER M-F 9-5 (**circle** one): **HOME** **WORK** **CELL**

Are you employed? _____ If yes, EMPLOYER NAME _____

EMPLOYER PH. # _____ FAX # _____

ADDRESS _____

ZIP _____ CITY _____ STATE_____

YOUR OCCUPATION _____

(If you are married, we need your spouse's information, please)

SPOUSE/SIG OTHER NAME _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

(if different) HOME PHONE _____ WORK PHONE _____

HOW DID YOU HEAR OF US? _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY STREET ADDRESS: _____

PHARMACY CITY,STATE,ZIP _____ PHONE _____

Do we have permission to import your medication history using our electronic prescription software? YES NO

EMERGENCY CONTACT INFORMATION (not your spouse/sig other)

CONTACT NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR VOICE MAIL or e-MAIL?

Please sign below if you give us permission to leave messages (such as test results) on your voice mail or e-mail:

SIGNED _____ DATE _____

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

INSURANCE INFORMATION FORM

Please take a few minutes to complete this form. All information provided is completely confidential. Thank you. We use this information only for medical insurance verification and billing.

PATIENT NAME _____ DATE _____

_____ I am insured under my own plan _____ I am insured under someone else's plan

DATE COVERAGE EFECTIVE _____

NAME OF POLICY HOLDER _____

SOCIAL SEC. NUMBER of POLICY HOLDER _____

INSURANCE COMPANY NAME _____

GROUP NUMBER _____ ID NUMBER _____

CLAIM FILING ADDRESS _____

ZIP _____ CITY _____ STATE_____

BILLING PH. # _____

CONTACT NAME _____ e-MAIL _____

PLAN WEB SITE _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

By signing below, I authorize Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to the doctor all insurance payments for medical services rendered and all major medical benefits. *I understand that I am personally obligated to pay for all medical services rendered, regardless of whether or how much my insurance company has paid.*

NAME _____ DATE _____

SIGNATURE _____

Insurance Verification

_____

_____

_____

Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

Explanation of Medical Billing

For all medical services we provide, we will submit a claim to your Insurance Plan. It is extremely important that we have accurate information about your plan. After we receive the EOB (explanation of benefits form), we will determine the amount, if any, that you still owe. Your statements will reflect this amount.

Introduction

Medical insurance involves 3 common forms of payment to physicians.
These are the **co-pay**, the **deductible** and the **co-insurance**.

The fee

Medical billing is called fee-for-service. The doctor provides services, and for each service, there is a fee (or a charge). The amount you owe is usually less than the full fee due to fee-reduction contracts between the doctor and your health insurance company. Contrary to what many people believe, insurance does not "cover everything".

The co-pay

The co-pay is the amount of money that you owe up front for every doctor visit. Each insurance plan is different. The co-pay might vary in amount or there might be none. The co-pay needs to be paid in advance at the time of your visit. Some co-pays are as high as $50.

The deductible

Many patients have an annual deductible. This is money that the insurance company will determine is owed to the physician, but that the patient has to pay. When a balance due is applied to your deductible, you owe this money to the practice. *See the example below.*

The co-insurance

This is the percentage of the fee that is owed to the practice based on your plan. The amount depends on what the insurance has approved for payment. You owe the co-insurance amount to the practice. *See the example below.*

Example using the above terms

You go to the doctor for a problem. The visit ***fee*** is $150. Your ***co-pay*** is $10 and this is paid at the time of the visit. A claim is filed with your insurance company. They approve a payment of $100.00, but you have a 20% ***co-insurance***.

The $100 is what your insurance has approved for the full payment for this visit. You have already paid $10 of this as your co-pay so the insurance owes $90. You have a ***co-insurance*** of 20%, so they will only pay 80% of the $90. Thus, they will pay only $72. Your co-insurance is $18. So you have paid $28 total ($10 co-pay plus the 20% or $18 co-insurance) and your insurance has paid $72.

If you have an unmet ***deductible***, the insurance will "apply" the entire $90 to your deductible. In this case, you owe the full $90 (but your deductible has been credited or reduced by $90).

Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Office and Financial Policies

We would like to thank you for choosing Fair Oaks Women's Health as your women's health care provider. This document explains our current office and financial policies. It is important that you read and agree to these policies.

No-Shows: If you cannot keep your scheduled Gyn appointment, please call our office at least 24 hours in advance to reschedule. This will allow us to offer that time to another patient. Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment is a **no-show** and will result in a charge of $25. This fee may be waived depending on your circumstances and will be waived if you make and keep your next appt.

Late Arrivals: You are expected to arrive on time for your scheduled appointments. New patients should plan to arrive 30 minutes early to allow for completing forms and updating your electronic medical record in the computer. If you are more than 15 minutes late, we may have to reschedule your appointment.

Fair Oaks Women's Health accepts Cash, Personal Checks, Travelers Checks, MasterCard, Visa, American Express Cards and ATM debit cards as payment for services rendered.

Financial Responsibility: Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.

Insured Patients: Please bring your insurance card with you to your appointment. If your insurance plan requires an office visit co-pay, this will be collected at the time of service. The co-pay cannot be waived by our office; it is a requirement placed on us by your insurance carrier. You are financially responsible for any co-insurance, deductible or non-covered service. If you are a member of a health plan that Fair Oaks Women's Health participates with, we will submit a claim to your insurance company on your behalf.

Balance Due: Once we have received payment along with an Explanation Of Benefits (EOB) from your insurance plan, you will receive a statement from our office indicating what your insurance has paid. Any remaining balance will then be due and payable. Patients with large deductibles will be asked to pre-pay a portion of their known medical expenses (for example, pregnant or gyn surgery patients)

Non Insured Patients: Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager.

Medicare Patients: You are personally responsible for your deductible, co-insurance and any services that Medicare deems as "Medically Unnecessary". Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for certain services.

Returned Checks: A $25 fee will be assessed for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

Disability Forms: A $20 fee will be charged for processing and mailing each disability form. These forms have become longer and more complicated and require a lot of administrative time to handle.

Medical Records Request: There is a $25 fee for a medical records request. Payment for these records will be collected prior to records being released. A complimentary copy of your records will be sent to the physician of your choice.

Collection Accounts: Fair Oaks Women's Health reserves the right to turn an account over to collections if it is deemed that the account is in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collections fees, including court costs, collections agency fees and attorney's fees incurred by us in enforcing the terms hereof, whether or not formal legal proceedings are commenced.

Financial Hardship: We understand that sometimes it is a hardship to pay your medical bills timely. Please meet with our Office Manger so we can work out a payment plan. Ignoring medical bills is not advisable. Let us know your situation so we can work with you.

Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Acknowledgement of Receipt of and Agreement with the Office and Financial Policies

I have read and I understand the handout, ***Office and Financial Policies***.

I authorize the physicians of Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to Fair Oaks Women's Health all insurance payments for services rendered and all major medical benefits.

I understand that I am personally obligated to pay for all medical services rendered regardless of whether or how much my insurance company has paid.

By signing below, I am stating that I understand and I agree to the above policies.

NAME _____ DATE _____

SIGNATURE _____

(Please sign and return this page to us. We will provide a copy upon request).

Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY.

HIPPA PRIVACY NOTICE

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer (see end of Notice).

How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. (We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.) We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice. However, this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the paragraphs headed treatment, payment, health care operations, and notification and communication with family, of this Notice of Privacy Practices, or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area. We will also post the current notice on our website (www.fowh.com)

Complaints. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services in Washington, DC. You will not be penalized for filing a complaint.

Privacy Officer: Mercedes Bin
Effective October 2010

Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. Please sign below.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate: _____

"Signed by" Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

****

Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address: _____

_____

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: ☐ Yes ☐ No	Date of Practice Follow-up:

Complete the following only if the Patient declines to sign the Acknowledgment:

Efforts to obtain:

_____

_____

Reasons for refusal

_____

Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization allows the release of confidential medical records to Fair Oaks Women's Health.

1. Patient Information

_____
Patient Name *Date of Birth*

_____
Street Address *City* *State* *Zip*

_____
Phone *e-mail* *Fax*

2. TO: Healthcare Provider or Facility

_____
Name of MD or Medical Facility *Address* *City* *State* *Zip*

_____
Phone *Fax*

3. Purpose of Records/Medical Information Release: _____

4. Please RELEASE my medical information to:

Fair Oaks Women's Health (Drs. Bryan Jick, Jennifer Park, Della Fong and Michael Mitri)
625 S. Fair Oaks Ave., Suite 255, Pasadena, CA 91105
Phone: 626-304-2626 Fax: 626-585-0695 e-mail: obgyn@fowh.com

5. Authorization

I hereby authorize the above healthcare provider or facility to release information regarding my medical history, illnesses or injuries; consultations, prescriptions, treatments, diagnoses or prognoses; including images, correspondence and/or medical records; by means of mail, fax or other electronic methods.

I authorize the release of the information specified below:

- ☐ My health information related to drug/alcohol/substance abuse.
- ☐ My health information related to psychological/psychiatric/mental health.
- ☐ My health information related to HIV/AIDS/STD diagnosis and/or treatment.
- ☐ My health information related to the following treatment or conditions:

  _____
- ☐ All my health information including substance abuse, mental health and HIV/AIDS/STD related.

6. Duration: This authorization is effective immediately and will remain in effect until _____
Date

7. Restrictions

Permissions for further use or disclose of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

_____
Signature of Patient *(or legal representative)* Patient name (print) Date

_____
Witness signature Witness name (print) Date

Bryan S. Jick, MD, FACOG
Jennifer Y. Park, MD, FACOG
Della J. Fong, MD, FACOG
Michael S. Mitri, MD
Diane K. Guerrero, RNC, WHNP
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

drjick@fowh.com
drpark@fowh.com
drfong@fowh.com
drmitri@fowh.com
www.fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Thank you for answering all of the following questions. Your health is important to us. Congratulations!

OBSTETRICS PATIENT HISTORY FORM

TODAY'S DATE _____ Your age_____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First)_____ (M.I.) _____

Your spouse/partner's full name _____

REFERRED HERE BY _____

1. CURRENT PREGNANCY

What was the FIRST day of the last menstrual period? _____ Is this date definite? (Y/N) _____

Cycles regular? (Y/N) _____ Cycle length (avg=28 days) _____ Date of first pos. preg. test _____

Conception (check one): _____normal Date of conception? _____ ____ IUI (date_____)

___IVF fresh cycle (date of egg retrieval _____) ____IVF frozen embryo (Date of embryo transfer _____)

What was your weight just before becoming pregnant? _____ What is your height? _____

When was your last pap smear? _____By whom? _____ Was it normal? YES NO

2. PAST PREGNANCY DETAILS

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Date of Delivery	# weeks at Delivery	Length of Labor	Birth Wght.	M F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location

3. PATIENT MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate)

X if YES	Condition	Comments
	1. Diabetes (type 1, type 2 or previous gestational diabetes). Any medication taken?	
	2. High Blood Pressure (hypertension now or in the past or with a prior pregnancy):	
	3. Heart Disease (fainting, heart murmurs, abnormal rate or rhythm, prior heart attack, abnormal valves):	
	4. Autoimmune Disorder (Lupus, Rheumatoid Arthritis, Fibromyalgia or other related conditions):	
	5. Kidney Disease or Urinary Tract Infections (UTI) (recurrent UTI, kidney stones):	
	6. Seizure Disorder or Neurologic Disease (migraines, epilepsy, history of TIA or stroke):	
	7. Mental Health Condition (includes anxiety or panic attacks, OCD, bipolar disorder, eating disorder):	
	8. History of Depression or Postpartum Depression (mild or severe, suicide attempts, hospitalization ever):	
	9. Gastrointestinal or Liver Disease (irritable bowel syndrome [IBS], Crohn's Disease, Ulcerative Colitis,	
	10. Varicose Veins or Blood Clots in Veins (pulmonary embolism, DVT – deep vein thrombosis):	
	11. Thyroid Disease (under or over active thyroid, thyroid cancer or radiation):	
	12. Domestic Violence (now or ever in the past):	
	13. History of Blood Disorders or Transfusion (anemia, blood clotting problem, transfusion ever):	
	14. Smoking History (current or former smoker):	
	15. Alcohol Use History (current or past use or abuse of alcohol):	
	16. Illicit or Recreational Drug Use History (current or past use or abuse):	
	17. Rh Disease or Rh Negative	
	18. Lung Disease (asthma, chronic bronchitis, TB):	
	19. Seasonal Allergies (hay fever, asthma):	
	21. Breast Disease or Breast Surgery (implants above the muscle, under the muscle, breast reduction):	
	23. Complications of Anesthesia (describe):	
	25. History of Abnormal Pap Smear (any treatments such as freezing, LEEP or cone biopsy and when):	
	26. History of Uterine Abnormality (double uterus, unicornuate uterus):	
	27. History of Infertility or IVF, IUI, insems?	
	28. Low Back Problems or Back Surgery?	

*Note – some numbers are skipped due to this data being entered into the EMR

4. SURGERY or HOSPITAL ADMISSIONS

Surgery or Hospital Admission - Details	Year

5. SYMPTOMS SINCE BECOMING PREGNANT

(Are you currently experiencing any of the following symptoms?)
(If so, please indicate with an X)

General
_____ Fatigue or Weakness
_____ Fever, Chills or Sweats
_____ Loss of Appetite

Eyes, Ears, Nose and Throat
_____ Nose Bleeds
_____ Sore Throat
_____ Vision or Hearing Changes

Breasts
_____ Breast Lump
_____ Breast Pain or Tenderness
_____ Nipple Discharge (other than white)

Cardiovascular
_____ Chest Pain
_____ Irregular Heartbeat or Palpitations

Respiratory
_____ Chronic Cough
_____ Shortness of Breath
_____ Wheezing

Gastrointestinal
_____ Diarrhea (watery stool)
_____ Heartburn
_____ Nausea or Vomiting
_____ Severe Constipation

Urinary
_____ Burning with Urination
_____ Leakage of Urine
_____ Waking at night 2 or more times

Skin
_____ Itching
_____ Moles or Sores
_____ Rash

Neurologic
_____ Dizziness
_____Headaches
_____ Migraines
_____ Memory Problems

Musculoskeletal
_____ Joint Pain (Back, Knee, Wrist, Hip)
_____ Joint Swelling
_____ Muscle Cramping or Pain

Psychological
_____ Anxiety, Worries, Stress (Excessive)
_____ Depressed
_____ Feeling Out of Control

Comments or Additional Symptoms Not Listed Above?

_____

_____

_____

6. GENETIC SCREENING

(If you or **ANY** close relative of yours - such as brothers, sisters, parents, other children - has EVER HAD or CURRENTLY HAS any of the problems listed below, please CIRCLE YES)

1. IS PATIENT GOING TO BE AGE 35 BY THE DUE DATE?	YES NO
2. HISTORY of THALASSEMIA or HEMOGLOBIN DISORDER	YES NO
3. HISTORY of NEURAL TUBE DEFECT (spina bifida)	YES NO
4. HISTORY of CONGENITAL HEART DEFECT	YES NO
5. HISTORY of DOWN SYNDROME	YES NO
6. &7. IS THE MOTHER OR FATHER OF THE BABY ASHKENAZI JEWISH or CAJUN? If yes, has any genetic testing been done?	YES NO Yes No
8. HISTORY of SICKLE-CELL ANEMIA or SICKLE-TRAIT	YES NO
9. HISTORY of HEMOPHILIA	YES NO
10. HISTORY of MUSCULAR DYSTROPHY	YES NO
11. A. HISTORY of CYSTIC FIBROSIS B. IS THE MOTHER or THE FATHER OF THE BABY CAUCASIAN/EUROPEAN?	YES NO YES NO
12. HISTORY of HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA)	YES NO
13. HISTORY of MENTAL RETARDATION If yes, was testing for Fragile X chromosome done?	YES NO Yes No
14. HISTORY of ANY INHERITABLE GENETIC SYNDROME or ANY BIRTH DEFECTS	YES NO
15. HISTORY of MATERNAL PKU OR OTHER METABOLIC SYNDROME	YES NO
16. PATIENT OR BABY'S FATHER HAD A CHILD WITH ANY BIRTH DEFECTS	YES NO
17. HISTORY OF STILLBIRTH OR 2 OR MORE MISCARRIAGES	YES NO
18. ANY HISTORY OF ILLICIT DRUG USE SINCE LAST MENSTRUAL PERIOD	YES NO

7. PRESCRIPTION MEDICATIONS YOU ARE TAKING

List name of medication, dose, and reason

8. DRUG STORE MEDICATION, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

List name of product and dosage

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____ Fax # _____

Do we have permission to import your medication history using our electronic prescription software? YES NO

Pt Name: _____

ALLERGIES (circle choices)

Do you have any known allergies? NO ALLERGIES Allergic to Latex? YES NO

If yes, please list all allergies and your allergic reaction

Allergic to	Reaction

9. INFECTION HISTORY

1. DO YOU LIVE WITH SOMEONE WHO MIGHT HAVE TUBERCULOSIS?	YES NO
2. DO YOU or YOUR PARTNER HAVE A HISTORY OF **GENITAL** HERPES?	YES NO
3. HAVE YOU HAD A SKIN RASH or VIRAL ILLNESS SINCE YOUR LAST PERIOD?	YES NO
4. HAVE YOU EVER TESTED POSITIVE FOR HEPATITIS B OR C ?	YES NO
5. HAVE YOU EVER HAD GONORRHEA, SYPHYLLIS, CHLAMYDIA, HIV or VENEREAL WARTS? (circle any that apply)	YES NO
6. DO YOU OR YOUR PARTNER HAVE A HISTORY OF A BLOOD TRANSFUSION OR A HISTORY OF IV DRUG USE?	YES NO

10. FAMILY MEDICAL HISTORY

*(If **ANY** close relative of yours - such as maternal and/or paternal grandparents, parents, brothers, and sisters – has EVER HAD or CURRENTLY HAS any of the problems listed below.*

CONDITION	Please CIRCLE CONDITION and indicate who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, STROKE	
3. TUBERCULOSIS, ASTHMA, OTHER LUNG DISEASE	
4. BREAST DISEASE, BREAST CANCER	
5. STOMACH, GI or COLON DISEASE or CANCER	
6. KIDNEY DISEASE, KIDNEY STONES	
7. GYN DISEASES, OVARIAN CANCER, UTERINE FIBROIDS	
8. MUSCULOSKELETAL DISEASE, OSTEOPOROSIS	
9. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
10. SEVERE DEPRESSION or OTHER PSYCHIATRIC CONDITION	
11. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
12. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
13. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	
14. ANY TYPE of CANCER or MALIGNANT TUMORS	

11. ADDITIONAL PREGNANCY ISSUES

1. It is now advised to screen all pregnant women for the HIV virus. This will be added to your initial prenatal labs unless you decline	YES	NO	TALK TO ME
2. Have you heard about Nuchal Translucency testing for Down Syndrome? (We will discuss this during your first visits.)	YES	NO	MAYBE
3. Have you heard about the MaterniT21 test for fetal DNA in the mother's bloodstream? If you are 34 or over, you might be a candidate	YES	NO	MAYBE
4. Do you get 3 servings per day of dairy products (milk, yogurt, cheese)? If not, we advise a daily Calcium Supplement (like CitraCal) with Vit D	YES	NO	
5. Do you own any cats? If so, it is advised that pregnant women not change the cat litter	YES	NO	
6. Are there any known or suspected hazards in your workplace? What is your occupation? _____	YES	NO	MAYBE
7. Do you have plane trips planned during this pregnancy? If so, we generally advise not flying after 32 weeks gestational age	YES	NO	MAYBE
8. In the past year, have you been threatened, hit, slapped or kicked by anyone you know or do you feel unsafe where you live?	YES	NO	TALK TO ME
9. Do you use a seat belt 100% of the time while driving?	YES	NO	
10. Are you considering having a tubal ligation (permanent sterilization)?	YES	NO	MAYBE
11. If you have a boy, do you want him circumcised?	YES	NO	MAYBE
12. Have you ever had chicken pox? If not, have you been vaccinated or have you already tested immune?	YES YES	NO NO	MAYBE
13. Have you ever tested positive for Vaginal Strep B or Group B Strep?	YES	NO	MAYBE
14. Do you plan to save the baby's umbilical cord blood at the time of delivery or would you like more information about this?	YES	NO	MAYBE
15. If you already have a Pediatrician, please enter their name. Is this doctor on staff at Huntington Hospital?	Dr. _____ YES	NO	MAYBE
16. Please see our OB guide on the web at: www.pasadenapregnancy.com			

It is not necessary to have made all of the above decisions yet.
We will discuss all pregnancy issues and your concerns at your consultation and throughout your pregnancy.
The above list is to help you as you begin to explore some of these issues

Notes or Questions for the Doctor: _____

_____

_____

_____

_____

_____

_____

_____

Revised February 2014