Sugar Land Women's Health

17510 W. Grand Parkway S. Suite 430
Sugar Land, TX 77479

713-578-3823 (office)
281-232-3349 (fax)

Chau Nguyen-Tran, MD Lauren Phillips, MD Michelle Wong, MD

Obstetrics and Gynecology

Patient Questionnaire

Patient

Name _____ Date _____

Address _____ City, State, Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Date of Birth _____ SS # _____ Drivers License # _____

Marital Status: Single ___ Married ___ Divorced ___ Widow ___ Occupation _____

Employer / School _____ Address _____

Who referred you to our office? Insurance Co. Friend / Relative Physician Other _____

Person to notify in case of an emergency. Name _____ Relation _____ Phone# _____

Spouse / Parent / Guardian

Name _____ Date of Birth _____ SS# _____

Employer / School _____ Phone # _____ Address _____

Insurance Information

Primary Insurance

Policy Holder's Name _____ Date of Birth _____ SS# _____

Ins Co. _____ Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Claims Address _____ City, State, Zip _____

Group Number _____ Policy/ID Number _____

Secondary Insurance

Policy Holder's Name _____ Date of Birth _____ SS# _____

Ins Co. _____ Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Claims Address _____ City, State, Zip _____

Group Number _____ Policy/ID Number _____

OGA

Authorization for Disclosure of Protected Health Information via Alternative Means

Please print all information, then sign and date authorization form at bottom.

Type of Authorization: It is the policy of this OGA to provide communication with patients, as stated in our Notice of Privacy Practices, "by phone or other means to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care". OGA requires the following authorization for release of protected health information via alternative means (other than your primary home phone). Alternative means may be cell phone, home phone, or US Mail.

Patient Name *(please print)* _____

Purpose of request - I authorize OGA to disclose or provide protected health information (as described below) in the manner I have indicated below (check one). I understand that it is my responsibility to notify OGA of any change in this manner of communication.

_____ cell phone ____ US Mail home address

_____ home phone

Description of information to be disclosed - I authorize OGA to disclose the following protected health information about me *(please provide a written description of the information to be disclosed, such as results of exams, laboratory tests, procedures, and other healthcare)*:

_____

_____

_____

Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my protected health information to ensure the confidentiality of communications with OGA.

Expirations or termination of authorization – This authorization will expire at the end of ninety days. I have the option to establish a specific expiration date and have established such date, if applicable, below.

(*Please list optional expiration date*):_____

Right to revoke or terminate – As stated in OGA's Notice of Privacy Practices, I have the right to revoke or terminate this authorization by submitting a written request to OGA's Privacy Manager. This can be done in-person or by mailing a request to OGA, Attn Privacy Manager.

Re-disclosure – I understand that OGA has no control regarding persons who may have access to the requested alternative means of communication I have listed to receive my protected health information. Therefore, I understand that my protected health information, disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of OGA.

_____ _____

patient signature date

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Welcome to Sugar Land Women's Health!

Please take a moment to let us know how you heard about us. Circle one below.

- Referral by doctor. If so, who? _____
- Referral by patient. Whom may we thank? _____
- Practice Website: select one:
    1. www.mysugarlandobgyn.com
    2. www.obgynassociates.com
    3. www.laurenphillipsmd.com
- Online scheduling: Zoc Doc or Schedule Now
- Insurance website or listing. Which insurance? _____
- Hospital Website. Which hospital? _____
- Other website: Healthgrades, vitals.com, ucomparehealthcare, google ad
- Magazine Ad:
    1. Greatwood or New Territory Monthly
    2. Ft. Bend Focus on Women
- Health Fair/symposium/public event. Which one? _____
- Other _____

Obstetrical and Gynecological Associates, P.A.

Date_____ Name_____ Age_____

Reason for today's visit? Preventative or Problem Visit (please circle one)

_____

Gynecologic History:

Pregnancies_____ Deliveries_____ Miscarriages_____ Abortions_____ Living children_____

Last menstrual period _____ Are periods regular?_____ Any problems with periods?_____

_____

At what age did your periods begin?_____

Are you trying to get pregnant?_____

Present type of contraception_____ Do you want to change?_____ To What?_____

Date of last Pap smear_____ Results_____

Y/N Have you ever had an abnormal pap or HPV test? Treatment?_____

Date of last Mammogram_____ Results_____

Y/N Have you ever had an abnormal mammogram or exam? Treatment?_____

Y/N Have you had a bone densitometry? When?_____ Results?_____

Y/N Have you had a colonoscopy? When?_____ Results?_____

Y/N Are you sexually active? Any difficulties or discomfort?_____

Age at 1st intercourse_____ Total number of sexual partners_____

Sexual preference: M / F / Both Number of current sexual partners_____

Y/N Do you perform breast self exams? Any changes or concerns? _____

Y/N Any vaginal discharge atypical for you? Itching?_____ Odor?_____

Y/N Any bladder leakage? Explain_____

Y/N Have you ever had any sexually transmitted infections? What?_____

(ex. Herpes, Gonorrhea, Chlamydia, Trichomonas, HIV, Hepatitis B or C, Syphilis, HPV)

Y/N Are you involved in an abusive relationship?_____

Obstetrical History:

List pregnancies in chronological order:

Year	Sex	Baby's Weight	Hours in labor	Anesthesia	Vaginal or C-section	Complications	Child's name

Medications:

Drug allergies_____

Medications list (include herbal and over-the-counter meds; include dosages for all)

_____

_____

_____

Surgical History: (include approximate date)

_____

_____

_____

_____

Social History:

Occupation:_____ Marital status: single/ married _____# years/ divorced/ widowed

Y/N Do you smoke? How much?_____

Y/N Do you drink alcohol? How much?_____

Y/N Do you use recreational drugs? Type & How much?_____

Y/N Do you exercise? How much? _____

Medical History:

Have **YOU** been treated for any of the following medical conditions? (please circle)

Seizures / epilepsy	Hepatitis – Type ____	Skin problems
Stroke	Colon Problems	Lupus
Migraines	Intestinal disease	Cancer – Type _____
Thyroid disease	Gallbladder disease	Blood clots
Heart problems	Kidney disease	Glaucoma
Heart attack	Kidney stones	High blood pressure
Asthma or pneumonia	Recurrent urinary infections	High cholesterol
Tuberculosis	Arthritis	Diabetes
Ulcers or reflux	Neurologic disease	Psychiatric problem

Please explain item above, or list other medical problems not listed:_____

_____

_____

_____

Family History:

Is there a member of your <u>immediate</u> family with any of the following medical conditions?

Y/N Diabetes? Who?_____ Appx. age of onset_____

Y/N Heart disease? Who?_____ Appx. age of onset_____

Y/N High Blood Pressure? Who?_____ Appx. age of onset_____

Y/N High Cholesterol? Who?_____ Appx. age of onset_____

Y/N Osteoporosis? Who?_____ Appx. age of onset_____

Y/N Are you of Ashkenazi Jewish descent?

Please indicate any cancer diagnoses in your family:

Cancer Type	Yes	Relationship to you	Age at diagnosis	Living Y/N
Breast cancer				
Male breast cancer				
Multiple breast cancers in 1 individual				
Ovarian cancer				
Colon cancer				
Multiple colon cancers in 1 individual				
10 or more colon polyps in 1 individual				
Uterine (endometrial) cancer				
Stomach cancer				
Kidney / urinary tract cancer				
Brain cancer				
Small bowel cancer				
Billiary cancer				
Melanoma				
Pancreatic cancer				

List other significant medical problems or cancers in family members:

_____

_____

Please provide name and number of all other treating physicians and their specialty:

_____

_____

Do you allow us to discuss your results with them? Yes / No (circle one)

Signature_____