

## Gynecology History Review/Update

Name: \_\_\_\_\_ LMP(FIRST DAY OF LAST PERIOD) \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Children: \_\_\_\_\_ Allergies: \_\_\_\_\_

Pets: \_\_\_\_\_ Medications: \_\_\_\_\_

Tobacco:        Yes    No        # of cigarettes/day \_\_\_\_\_ # of years \_\_\_\_\_

Alcohol:        Yes    No        # of drinks/week \_\_\_\_\_ type \_\_\_\_\_

Drugs:            Yes    No        \_\_\_\_\_

Exercise:        Yes    No        # of times/week \_\_\_\_\_ type \_\_\_\_\_

Health Care Advance Directive:    Yes                    No

Seat belt use                                Yes                    No

Do you feel safe at home                Yes                    No

Primary Care Physician                Yes                    No                    Name: \_\_\_\_\_

Pharmacy                                    Name: \_\_\_\_\_ Location: \_\_\_\_\_

May we discuss your health information with a family member/friend?

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

### REVIEW OF SYSTEMS    Please check all that are applicable (within the last 6-12 months)

**OB/GYN:**                     Abnormal bleeding/menses     Mid Cycle bleeding                     Bleeding after sex  
 Pain with menses                     Vulvar pain                                 Pelvic pain  
 Vaginal dryness                     Vaginal odor                                 Vaginal itching

**Sex:**                                 No Orgasm                                 Decreased libido                     Pain with intercourse

**Breast:**                                 Breast lump                                 Breast pain                                 Breast discharge

**Menopause:**                     Hot Flash                                     Night Sweats                                 Hair/Skin change

**URINE:**                                 Frequency                                     Pain with urine                                 Nocturia

Stress incontinence                     Urge incontinence

**CONSTITUTIONAL:**             Fever/Chills                                 Recent weight change                     Feeling Tired

**EYES:**                                     Visual Migraine                                 Vision Changes                                 Wears glasses

**EAR/NOSE/THROAT:**             Nosebleeds                                     Loss of hearing                                 Dental problems

**HEART:**                                 Chest pain                                     Heart rate is fast/slow                     Leg swelling (Edema)

**LUNGS:**                                 Shortness of breath                                 Cough     Wheezing

**ABDOMEN:**                                 Abdominal pain                                 Heartburn     Bloating

Constipation/Diarrhea                     Black stool (Blood)                                 Nausea Vomiting

**BONE/MUSCLE:**                     Joint/Limb pain                                 Back pain     Limb weakness

**SKIN:**                                     Acne     Itching/Rash                                         Change in a mole

**NEUROLOGICAL:**                     Confused     Dizziness     Memory problems

Headaches/Migraines                     Difficulty walking

**PSYCHIATRIC:**                     Suicidal     Personality Change                                 Sleep disturbances

Depression     Anxiety     Emotional problems

**IMMUNE:**                                 Easy bleeding/bruising                     Swollen glands                                         Seasonal Allergies

**Mary Margaret O’Neill, MD, Inc. (dba Cedar Ob/Gyn)**  
**Consents – Treatment, Billing, HIPAA**

**Consent for treatment**

- I hereby consent to and authorize the administration of all diagnostic procedures, medical treatment, anesthetics and surgical procedures deemed necessary by Mary Margaret O’Neill, MD.

**Financial and Insurance Authorization**

- I authorize direct payment of insurance benefits to Mary Margaret O’Neill, MD for services rendered by her in person or under her supervision. I understand that I am financially responsible for my account regardless of my insurance. It is my responsibility to know & understand my insurance policy & benefits. -

- This includes referrals, copayments, covered lab & X-ray benefits, and prior authorizations for procedures. I further understand that if I enroll in another insurance plan, it is my responsibility to notify the health care provider; otherwise I will be responsible for payments.

- Any charges which are either for medical care not covered by my policy or as a result of not following the required procedures of my health plan are my financial responsibility.

-All copayments are due in full at the time of service. All other charges are due within 60 days from time of service.

- I authorize the release of all medical information necessary to secure payment of benefits & request the payment of medical benefits be made directly to Dr. Mary Margaret O’Neill unless payment is made full at the time of service.

**Prescription History**

- I authorize the office of Mary Margaret O’Neill, MD to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

**HIPAA Acknowledgement**

- I hereby acknowledge that I have received a copy of Mary Margaret O’Neill, MD’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available at each appointment.

**Consent to Access Health Information via the Internet**

- I hereby acknowledge that I have received a copy of Mary Margaret O’Neill, MD’s, Consent to Access Health information via the Internet using a Secure Patient Portal electronic application form and agree to the terms and conditions. I further acknowledge that a copy of the current notice will be available at each appointment.

**Notice to Consumers regarding your Health Care Practitioner**

Name & License: Mary Margaret O’Neill CA: G69694 Academic Degree: MD

Board Certification: American Board of Obstetrics and Gynecology

Medical doctors are licensed and regulated by the Medical Board of California.

(800) 633-2322. [www.mbc.ca.gov](http://www.mbc.ca.gov)

**I would like a chaperone in the exam room during the pelvic exam/PAP. Yes \_\_\_\_\_ No \_\_\_\_\_**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ eMail: \_\_\_\_\_

\_\_\_ Please check here if you do NOT want appointment reminders via email or text