PATIENT NAME:____ **DATE FIRST COMPLETED**______

PERSONAL AND FAMILY HEALTH HISTORY

(Please include Yourself, Mom, Dad, Siblings, Aunts, Uncles, and Grandparents)

	Self	Family	Comments		Self	Family	Comments
HEART				**NEUROLOGICAL**			
Stroke				Alzheimer's Disease			
Heart Attack				Cerebral Palsy			
Heart Disease				Down's Syndrome			
Coronary Artery Disease				Epilepsy/Seizures			
High Blood Pressure				Huntington's Disease			
High Cholesterol				Hydrocephalus			
Blood Clots Legs/Lungs				Mental Retardation			
Other				Migraines			
BLOOD				Multiple Sclerosis			
Anemia				Parkinson's Disease			
Bleeding Disorders				Neural Tube Defects			
HIV virus				Other			
Immune Deficiency				**MUSCLE/BONE/JOINTS**			
Leukemia/Lymphoma				Arthritis			
Other				Deformity of Spine			
RESPIRATORY				Scoliosis			
Asthma				Gout			
Emphysema				Lupus			
Hayfever/Allergies				Arthritis			
Lung Cancer				Osteoporosis			
Pneumonia				Other			
Tuberculosis				**SIGHT/SOUND/SMELL**			
Other				Blindness			
GASTRO-INTESTINAL				Cataracts before age 50			
Colon/Intestinal Cancer				Color Blindness			
Crohn's Disease				Deafness			
Cystic Fibrosis				Glaucoma			
Gall Stones				Other			
Hepatitis				**SKIN**			
Ulcerative Colitis				Acne			
Other				Eczema			
METABOLIC/ENDOCRINE				Skin Cancer			
Diabetes Mellitus				Pigmentation Disorder			
Thyroid Disease				Neurofibromatosis			
Hypoglycemia				Other			
Other				**OTHER DISORDERS**			
URINARY				Genetic Disorders			
Kidney Disease				Alcoholism			
Other				Drug Addiction			
MENTAL HEALTH				Breast Cancer			
Anxiety				Endometriosis			
Depression				Ovarian Cancer			
Bipolar Disorder				Uterine Cancer			
Physical/Sexual Abuse				Any Other Condition Not Mentioned			
Other							

Please Record Date and Initial Here When Form Updated: ______________________________

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LAKEVIEW OB/GYN CLINIC

Dr. Nathan Ward

GYNECOLOGY AND WOMEN'S HEALTH CARE

Name (First)______________________(Last____________________(Maiden)_________________Age__________

Reason for today's visit____Today' Date________________

MENSTRUAL HISTORY

Have you gone through menopause? Yes__________Year____________No__________ If "no" complete the following

Date of last period_________________How often do you have your period?_____________________________________

How many days do they last?_________________________ Are your periods painful? Yes____________No___________

What are you using for birth control now?____

When was your last pap smear?________________________When was your last mammogram?____________________

PREGNANCY HISTORY

How many times have you been pregnant?______________________How many living children?____________________

Have you had any C-sections? No____________Yes___________If "yes" how many______________________________

MEDICAL HISTORY

Do you have any allergies?____

Do you have any of these conditions:

Diabetes_________________ Asthma_______________ Seizures? Neurological disease___________

High blood pressure_________ Heart disease___________ Cancer_____________________________

Hepatitis_________________ Bowel disorders__________ Kidney/Urinary disease_______________

Blood clots legs/lungs________ Thyroid problems_________ Stomach/ulcer disease________________

Name all medications you are taking with the dosage:

Name of medication	Dosage

SOCIAL HISTORY (Habits)

Alcohol__________________________Tobacco____________________Street Drugs_________________

SURGICAL HISTORY

Year	Type of Surgery

FAMILY HISTORY

Do your mother or sisters suffer from?

Endometriosis_____________Breast cancer_____________Ovarian cancer_____________Uterine cancer_____________

Lakeview OB/GYN
Notice of Privacy Practices

Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Each time you visit our practice a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments and plan for future care. This notice applies to all of the records of your care generated by the practice.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

For Treatment

We may use medical information about you to provide you treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or the hospital personnel who are involved in taking care of you. For example: a doctor treating you for back pain may need to know you are pregnant. This will help him determine which path of test and treatment he can take.

For Payment:

We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or your health plan about treatment you are going to receive to determine whether your plan will cover it.

As required by Law:

We may also use and disclose health information for the following types of entities including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements:

Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the State privacy laws are more stringent than Federal privacy laws, the State law preempts the Federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:

- **Inspect and Copy**: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request. We will comply with the outcome of the review.
- **Amend**: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial
- **An Accounting of Disclosures**: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your medical information for purposes other than treatment, payment or health care operations.
- **Request Restrictions**: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.**
- **Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. The practice will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by practice and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice**: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Other uses of Medical Information:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

HCA Physician Services
Lakeview OB/GYN Clinic

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Lakeview OB/GYN Clinic** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Lakeview OB/GYN Clinic** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Lakeview OB/GYN Clinic**.

I acknowledge that I have been given the **Lakeview OB/GYN Clinic** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: ____________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ______________

Patient (or Responsible Party) Signature ***Date***