New Patient/Annual

Vitals: Height _________ Weight _________ BP _________ HR _________ Temp _________ LMP ______________

Date: _______________ Name: _______________________________________ D.O.B. ____________ Age: ________
Change of address: ____
Referred by: ____
Employer/Occupation: ____
Single Married Divorced Widowed Spouse's name: _______________________________________

Reason for visit: Well Woman Exam Problem Visit Both**

****I understand that if I am being seen for a problem with my Well Woman visit, I may be charged a co-pay for the problem visit. ______initials**

Problem: ____
When did it start? ____________________________________ Mild Moderate Severe
What makes it better or worse? ____
How has it been treated? ____

Menstrual History:

Last menstrual period: _________________ Menstrual cycle: regular irregular Painful periods? Yes No
Amount of flow: light medium heavy clots
Was last menstrual period normal? Yes No If no, when was the last normal one? _________________________
Number of days between cycles: ________ Cycle lasts ________ days Age when menstrual cycle started_________

Pregnancy History:

Total # of pregnancies	# of Full Term Births (37-42 weeks)	# of Preterm (20-36 weeks)	# of induced abortions (before 20 weeks)	# of spontaneous abortions/ miscarriages (before 20 weeks)	# of ectopic pregnancies	# of multiple births	# of Living children

#	Date	# weeks pregnant	# hours of in labor	Baby's weight	Type of delivery	Type of anesthesia	Place of delivery	Complications	Baby's sex
1									
2									
3									
4									

PREVENTATIVE HEALTH	Year	History of abnormality:	If yes, when?	Abnormality?	Treatment?
Last Pap Smear		Yes No			
Last Mammogram		Yes No			
Last Colonoscopy		Yes No			
Last Bone Density Scan		Yes No		Osteopenia Osteoporosis	

Recommended follow up colonoscopy is in _______ months/years
Cholesterol was last checked: _____________
Types of past contraceptives: Oral Contraceptive Pills Mirena Liletta Skyla Nexplanon Other:___________
Current contraceptive(s): Oral Contraceptive Pills Mirena Liletta Skyla Nexplanon Other:________________
In the event of a life-threatening event, will you agree to accept a **transfusion of blood products**? Yes No

Are you sexually active? Yes No If yes, please explain____

Date ______________ Name ____ DOB ______________ Age ____________

Tobacco: Smoker Packs per day: _________ Former Smoker # of years:______ Quit date: __________ Never Smoker
Alcohol: How often do you drink? _________________ How much do you drink? ____________________ Never drinker
History of/Current **Drug use**: Marijuana Cocaine PCP Ketamine LSD Crack Ecstasy Methamphetamine Heroin Other: ___________

MEDICAL HISTORY: Circle the medical condition(s) you have ever had	
□ Heart Attack/Disease/Heart murmur	□ Stroke
□ Hypertension	□ High Cholesterol
□ Autoimmune Disorder/Arthritis/Fibromyalgia/Lupus/HIV/AIDS	□ Stomach Problems/GERD/Hernia/Ulcer
□ Kidney disease/Kidney stones/Kidney problems/UTI/Urinary Incontinence	□ Gall Bladder Problems
□ Neurologic/Epilepsy/Seizures/Migraine headaches/Aura	□ DES Daughter
□ Depression/Postpartum Depression/Anxiety	□ Diabetes/Gestational Diabetes
□ Hepatitis/Liver Disease/Jaundice	□ Cancer
□ Varicosities/Phlebitis/Blood Clot/Thrombosis/	□ Osteoporosis/Weak bones
□ Bowel Problems/Colitis/IBS/Polyps/Fecal Incontinence	□ Trauma/Violence/Broken Bones
□ Bleeding Disorder/Anemia/Sickle Cell Trait/Sickle Cell Disease	□ Eating disorder
□ History of blood transfusion	□ Eye problems/Glaucoma/Cataracts
□ Depression/Anxiety/Psychiatric problem	□ Breast Problems
□ Pulmonary (TB/Asthma/COPD/Pneumonia)	□ Hypothyroid/Hyperthyroid
□ Human Papilloma Virus (HPV), Genital Warts, Herpes, Hepatitis B, Hepatitis C, HIV/AIDS, Chlamydia, Gonorrhea, Trichomonas, Syphilis, Molluscum	

Medication Allergies: □ No known allergies

Allergy:	Reaction:

CURRENT MEDICATIONS: Please include prescriptions, herbal supplements and over the counter medications.				
Medication Name	Dose & frequency	Month & year started	Condition being treated	Prescriber

CURRENT PHARMACY:

CVS Walgreens Wal-Mart Kroger Tom Thumb KK's Flower Mound Pharmacy Long Prairie Pharmacy

CVS-CareMark Other: ____

Street: _______________________________________ City: ______________________________________ Zip: _______

Date _____________ Name ____ DOB _____________ Age ___________

Surgical History: □ No surgical history **Hospitalization:** □ No hospitalization history

Date	Surgery Type	Complications	Date	Hospitalization Reason

Family History: □ Adopted & family history is unknown. If checked, please list family member(s) with the condition. Please include mother, father, brother(s), sister(s), maternal aunt(s) or uncle(s), maternal grandmother(s) or grandfather(s), paternal aunt(s) or uncle(s), paternal grandmother(s) or grandfather(s), son(s) or daughter(s).

	Relationship	Mother's side	Father's side		Relationship	Mother's side	Father's side
□ High Blood Pressure				□ Diabetes			
□ Blood Clotting Disorder				□ Stroke			
□ High Cholesterol				□ Heart Disease			
□ Alzheimer's/Dementia				□ Tuberculosis			
□ Osteoporosis				□ Hepatitis			
□ Alcohol/Drug Abuse				□ HIV/AIDS			
□ Thyroid Dysfunction				□ Birth Defect			
□ Other:				□ Mental Illness			
				□ Depression			

FAMILY HISTORY QUESTIONNAIRE FOR COMMON HEREDITARY CANCER SYNDROMES

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY. Then, please list relationship of the individual diagnosed (mother, father, brother(s), sister(s), maternal aunt(s), maternal uncle(s), maternal grandmother(s), maternal grandfather(s), paternal aunt(s), paternal uncle(s), paternal grandmother(s), paternal grandfather(s), son(s) or daughter(s), & their age at diagnosis.

		Breast & Ovarian Cancer (BRCA)	Relationship	Mother's Side	Father's Side	Age Diagnosed
Y	N	Breast Cancer				
Y	N	Ovarian Cancer				
Y	N	Breast Cancer in both breasts or multiple primary Breast Cancers				
Y	N	Male Breast Cancer				
Y	N	Pancreatic Cancer				
Y	N	Are you of Jewish descent?				
Y	N	Triple Negative Breast Cancer				
Y	N	Family member with known BRCA Mutation				
		Colon & Uterine Cancer				
Y	N	Uterine (Endometrial) Cancer				
Y	N	Colon Cancer				
Y	N	Ovarian, Stomach, Kidney/Urinary Tract, Pancreatic, Brain or Small Bowel Cancer				
Y	N	10 or more Colon Polyps found in a lifetime (in an individual or a family)				

CURRENT PROBLEMS WHICH NEED TO BE ADDRESSED AT TODAY'S APPOINTMENT:

GENITOURINARY/GYN	EARS, NOSE, THROAT	MUSCULOSKELETAL
☐ Pain when urinating	☐ Ear pain	☐ Muscle weakness
☐ Frequent urination	☐ Ringing ears	☐ Muscle pain or stiffness
☐ Strong urgency to urinate	☐ Hearing difficulties	☐ Joint pain or stiffness
☐ Difficulty urinating	☐ Nose bleeds	☐ Back pain
☐ Bladder not emptying	☐ Congestion, runny nose	☐ Limited movement
☐ Blood in urine	☐ Mouth, gum, tongue sores	☐
☐ Leaking urine, incontinence	☐ Sore throat, voice changes	**ENDOCRINE**
☐ Genital sores	☐ Dental	☐ Heat intolerance
☐ Abnormal vaginal discharge	☐	☐ Cold intolerance
☐ Vaginal burning	**CARDIOVASCULAR**	☐ Excessive thirst & urination
☐ Vaginal itching	☐ Chest pain or pressure	☐ Hair loss
☐ Vaginal odor	☐ Shortness of breath	☐ Hot flashes
☐ Vaginal mass, protrusion	☐ Difficulty breathing	☐ Night sweats
☐ Abnormal vaginal bleeding	☐ Irregular heart beats	☐ Weight changes
☐ Abnormal periods	☐ Swelling (edema)	☐
☐ Painful periods	☐	**NEUROLOGIC**
☐ Premenstrual syndrome PMS	**PULMONARY**	☐ Dizziness or fainting
☐ Pelvic pain	☐ Wheezing	☐ Tremors
☐ Painful intercourse	☐ Cough	☐ Seizures
☐ Low sex drive/libido	☐ Coughing up blood	☐ Numbness, tingling
☐ Problems getting pregnant	☐ Short of breath	☐ Trouble with balance, walking
☐	☐ Painful breathing	☐ Unusual memory loss
BREAST & SKIN	☐	☐ Frequent or severe headache
☐ Breast pain	**GASTROINTESTINAL**	☐
☐ Breast lump, mass	☐ Diarrhea	**HEMATOLOGIC/LYMPH**
☐ Nipple discharge	☐ Constipation	☐ Abnormal bruising
☐ Rash or hives	☐ Abdominal pain	☐ Prolonged bleeding from cuts
☐ Sores, boils, abscesses, acne	☐ Gas, bloating	☐ Enlarged glands, lymph nodes
☐ Abnormal moles or warts	☐ Bloody stool or rectal bleeding	☐
☐ Dry, scaly skin or plaques	☐ Nausea	**ADDITIONAL NOTES**
☐	☐ Vomiting	
CONSTITUTIONAL	☐ Heartburn	
☐ Weakness, unusual fatigue	☐ Leaking stool, incontinence	
☐ Fever	☐ Hemorrhoids	
☐ Unintentional weight loss	☐	
☐ Abnormal weight gain	**PSYCHIATRIC**	
☐ Lack of appetite, anorexia	☐ Depressed mood	
☐	☐ Excessive anxiety	
EYES	☐ Extreme mood swings	
☐ Vision changes, problems	☐ Sleep disturbance	
☐ Wear glasses or contacts	☐ Unusual behaviors	
☐	☐ Ideas of hurting self, others	
	☐ Hearing or seeing things	
	☐	

Zika Virus Questionnaire:

1. In the past 4 weeks :
   Have you been in any of the areas on this list: If so please circle

- Anguilla
- Argentina
- Aruba
- Barbados
- Belize
- Bolivia
- Bonaire
- Brazil
- Colombia
- Costa Rica
- Cuba
- Curacao
- Denton, TX
- Dominica
- Dominican Republic
- Ecuador
- El Salvador
- Florida
- French Guiana
- Grenada
- Guadeloupe
- Guatemala
- Guyana
- Haiti
- Honduras
- Jamaica
- Martinique
- Mexico
- Nicaragua
- Panama
- Paraguay
- Peru
- Puerto Rico
- Saba
- Saint Barthélemy
- Saint Lucia
- Saint Martin
- Saint Vincent and the Grenadines
- Sint Eustatius
- Sint Maarten
- Suriname
- Trinidad and Tobago
- U.S. Virgin Islands
- Venezuela

Oceania/Pacific Islands

- American Samoa
- Fiji
- Kosrae, Federated States of Micronesia
- Marshall Islands
- New Caledonia
- Papua New Guinea
- Samoa
- Tonga

Africa

- Cape Verde

1. Have you had Zika Virus infection?
(Please circle) Yes / No

2. Have you had 2 or more of the following symptoms: Fever, rash, joint pain, muscle pain, conjunctivitis (pink eye), head ache?
(Please circle) Yes / No

3. Have you had sexual contact with a man, who in the 3 months prior to your sexual contact, had Zika virus infection or had 2 or more symptoms of Zika virus infection?
(Please circle) Yes / No

PATIENT REGISTRATION FORM

Women's Wellness at Flower Mound

Obstetrics, Gynecology, & Infertility

Sylvie H. Paroski, MD, FACOG • Cheryl Smitherman, DNP, CNM

Please clearly print your response to all requested information.
If you have any questions, please ask our staff. Thank you!

Name ______________________________________

Address ____________________________________

City _______________________________________

State _________ Zip___________

Date of Birth _______________________________

Employer __________________________________

Social Security # ___________________________

Single __ Married __ Divorced __Widowed __

Spouse's Name ___________________________

Home Phone (_____) _______ - _______

• Okay to leave a detailed message regarding results?

______ YES ______ NO

Cell Phone (_____) _______ - _______

Work Phone (_____) _______ - _______

• Okay to leave a detailed message regarding results?

______ YES ______ NO

Email Address ____________________________

• Okay to send you offers & information about healthcare?

______ YES ______ NO

HOLDER OF INSURANCE POLICY (You do not need to fill out if you are the policy holder)

Patients Relationship to policy holder ◯ Self ◯ Spouse ◯ Child ◯ Other_________________

Name ____

Home Address __________________________________

Employer ______________________________________

Social Security # ________________________________

Office Phone (_____) _______ - _______

City_______________ State_____ Zip_________

Occupation _______________________________

Date of Birth ______________________

EMERGENCY CONTACT INFORMATION

Name: ____ Relationship: _____________________________

Primary Telephone (_____) _______ - _______

I hereby assign all medical and/or surgical benefits, to include major medical to which I am entitled including Medicare, Private Insurance, PPO Plans, and all other health plans to Women's Wellness at Flower Mound, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges weather or not paid by said insurance. I hereby authorize said assignee to release all information needed to secure the payment.

Signature ____ Date ______________________________

PATIENT CONSENT FORM

I understand that as a part of my healthcare, Women's Wellness at Flower Mound, P.A. ("The PRACTICE") originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PRACTICE'S *Notice of Privacy Practices* provides specific information and complete descriptions of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice or Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PRACTICE is required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PRACTICE has already taken action in reliance on my prior consent. The consent is valid until revoked by me in writing.

I further understand that any and all records, weather written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PRACTICE'S *Notice of Privacy Practices 2017.*

__________________________________ ________________
Signature of Patient or Legal Representative Date

____
Print Name of Patient or Legal Representative

I hereby give my authorization to disclose my protected health information, only in the specific manner, for the named reason, and to the specific individual(s) below:

Specific description of information to be released:

____
____

Person(s) you allow to request and receive the information stated above:

____

I understand this authorization provides that:

- I have the right to access my protected health information to be used or disclosed.
- I may revoke this authorization at any time by contacting your Privacy Officer in writing at the address above.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use of disclosure.

Signature:______________________________ **Date:**______________________________

Relationship to patient (if signed by a representative of patient)______________________________

DISCLOSURE OF PHYSICIAN OWNERSHIP IN HEALTHCARE FACILITIES

Please carefully review the following information:

Dr. Sylvie Paroski MD, is required by federal and state law to disclose any ownership or financial interest in any healthcare facilities to which our patients may be referred. Your physician holds ownership interest in Texas Health Presbyterian Flower Mound ("THFM"). Please contact the scheduler at THFM for a current list of physician's owners or go to www.texashealthflowermound.com

We respect your right to choose not only your physician, but also where you wish to receive medical care. You will not be treated differently by your physician if you choose to use a different facility. We encourage you to ask questions or discuss any concerns you have with us at the time of your office visit.

ACKNOWLEDGMENT:

I have been notified, at the time of referral, that my physician and other treating physician(s) have an ownership interest in Texas Health Presbyterian Hospital Flower Mound. I further acknowledge this disclosure will be maintained in my medical record and made available to Texas Presbyterian Hospital Flower Mound.

Patient Name (please print):____

SIGNATURE

Patient: _________________________________ Date: __________________________

OR

Legal Representative: ____

Relationship to Patient: ____

Sylvie H. Paroski, MD, FACOG
Cheryl Smitherman, DNP, CNM

2017 Office Policy Charges

$25.00 - Appointments cancelled with less than 24 hours' notice.

$25.00 - No show to appointment.

$25.00 - FMLA / Disability Paperwork, if less than 10 day notice there will be an additional $5.00 charge.

$25.00 - Claims Paperwork, if less than 10 day notice there will be an additional $5.00 charge.

$25.00 – Medical Records not requested by physician.
Additional $5 per 100 pages after initial100 pages.
If less than 10 day notice there will be an additional $5.00 charge.
RECEIVE MEDICAL RECORDS UP TO 30 DAYS

Patient Signature: ______________________________ **Date:** ____________

Ofc: 972-355-9436 • Fax: 214-513-2244 • 3051 Churchill Dr., Suite 220 • Flower Mound, TX 75022
www.WomensWellnessFM.com

Dr. Sylvie H. Paroski, MD, FACOG

Cheryl Smitherman, DNP, CNM

Patient Financial Responsibility Statement Acknowledgement

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

____

Print Name

____ ______________________________

Signature of Patient or Guardian Date

For self-pay or if you are submitting to insurance on your own

Waiver of Patient Authorizations I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion. If you are self-pay there will be a separate bill from PathAdvantage for your pap smear that you are responsible for and all labs will be paid for at the time of visit.

____

Print Name

____ ______________________________

Signature of Patient or Guardian Date