Tree of Life Birth & Gynecology, LLC
1010 Arthur Ave
Orlando, FL 32804
P: 407.878.2757 F: 407.270.7117
www.TreeOfLifeBirthFL.com

Gynecology Questionnaire

Date: ____________________
Name: ____________________
Preferred Name: ____________________
Birth Date: ____________________
Birth Place: ____________________

Age: _____ G _____ P _____
S M Sep Div W
LMP: ____________________
Contra: ____________________

PRIMARY PROBLEM OR SYMPTOMS: (reason for today's visit)

____

____

How long has this gone on? 1 day ____ 1 week _____ 1 month ____ 1 year _____ 1+ years ________

OBSTETRICAL HISTORY:

Pregnancies: List in sequence from first to most recent, including miscarriages and abortions

	DATE	PLACE (city or hosp.)	SEX	WEIGHT	COMPLICATIONS
1)					
2)					
3)					
4)					
5)					

(use back of this page if more)

MEDICAL HISTORY:
List any illnesses, current or past, under the care of a physician (i.e, diabetes, etc.)

	Year	Diagnosis	Medications
1)			
2)			
3)			
4)			
5)			

Have you ever had any of the following? (circle if yes)

diabetes — asthma
heart murmur — high blood pressure
seizures — hepatitis
thyroid problem — mononucleosis (mono)
transfusion of blood or blood products
tuberculosis — migraine headaches

SURGICAL HISTORY: (list all operations giving date and city)

1) ____________________ | ____________________
2) ____________________ | ____________________
3) ____________________ | ____________________

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Have you ever had any hospitalizations other than above? Yes _____ No _________
(If yes, list on back of page)
Have you ever had any major injuries not listed above? Yes _____ No _____
(If yes, list on back of page)

ALLERGIES AND MEDICATIONS:

Are you allergic to any medications? _____ If yes, what? ______________________________
What type of reaction? ______________________________
List all medications you are presently taking, including vitamins/minerals:
____
____

GYNECOLOGICAL HISTORY:

	Yes	No
Menses:		
Last menstrual period began ____________		
Age when menses began ____________		
How many days do you bleed? ____________		
How many days between first days of each period? ________		
Do you clot with your menses?	____	____
Are your cycles irregular?	____	____
Date of last Pap smear ____________		
Have you ever had an abnormal Pap smear?	____	____
If yeas, when and what therapy did you receive? ________		
Pain:		
Do you have pain with your menses?	____	____
Do you have pain with ovulation?	____	____
Are you having sexual relations?	____	____
Are you having intercourse?	____	____
Do you have pain with intercourse?	____	____
Do you get satisfaction from your sexual relations?	____	____
Bleeding:		
Do you bleed between periods?	____	____
Do you bleed after intercourse?	____	____
Do you bleed from your rectum?	____	____
Have you had any recent change in your cycle?	____	____
Infection:		
Do you have a vaginal discharge?	____	____
Do you have any itching?	____	____
Do you have any burning?	____	____
Have you ever had a pelvic infection (PID)?	____	____
Have you ever had any of the following: (Check, if yes)		
Gonorrhea _____ Chlamydia _____ Herpes _____		
Syphilis _____ Genital warts _____		
Has your partner had any of the above? (If yes, list on back)	____	____
Contraception:		
Are you using a method of birth control?		
If so, which one(s)? (check below)		

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Condoms _____ Rhythm _____ Foam or Jelly alone _____ IUD _____
Sponge _____ Withdrawal _____ Diaphragm or cervical cap _____
Pill _____ Name of Pill _________________ How long? _________
Sterilization _____ tubal ligation/vasectomy (circle one)

	YES	NO
Are you dissatisfied with your current method of birth control?	____	____
Have you ever used the Pill?	____	____
Did you have any problems? (explain on the back)		
Have you ever used an IUD? Type _____________		
Did you ever have any problems? ______________________________		
Do you desire to have children in the future?	____	____
Have you had any of the following? (explain on back)		
Endometriosis?	____	____
Fibroids?	____	____
Ovarian cysts or tumors?	____	____
Breasts:		
Do you have discharge from your breasts?	____	____
Do you have any lump(s) in your breasts?	____	____
Do you check your breasts every month?	____	____
Have you ever had a mammogram? When _____________		
Have you ever had a breast biopsy? ____________		
Do you notice unusual hair growth on your breasts, face, or elsewhere?	____	____
Menopause:		
Are you bothered by hot flashes?	____	____
Do you have trouble sleeping?	____	____
Do you notice vaginal dryness?	____	____
Do you have night sweats?	____	____
Do you feel anxious?	____	____
Have you taken estrogens?	____	____
Have you lost weight?	____	____
Other problems? (list hormones that you are taking) _______________	____	____
Urinary:		
How often do you urinate? _____________		
Do you have a strong urge to urinate?	____	____
Do you have to hurry to the toilet?	____	____
Does the sight or sound or feel of running water cause you to lose urine?	____	____
Are you ever unaware that you are losing your urine?	____	____
Do you lose urine when you cough, laugh or sneeze?	____	____
Large or small amounts? _________		
Do you ever have to wear a pad?	____	____
Do you have a feeling of pressure or bearing down?	____	____
Do you have a bulging from your vagina?	____	____

FAMILY HISTORY:

Please list your natural parents' ages, whether they are still alive or deceased, and any major illnesses they have or had. Illnesses

Mother: Age _____ Alive _____ Dec. _____ ____________________
Father: Age _____ Alive _____ Dec. _____ ____________________

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Siblings: How many? ________ Illnesses ____________________
Has anyone in your family had any of the following? (include blood relatives, i.e., parents, grandparents, sisters, brothers, uncles, aunts, and children)

High blood pressure Who? ____________________
Heart attack Who? ____________________
Stroke Who? ____________________
Diabetes Who? ____________________
Breast cancer Who? ____________________
Colon cancer Who? ____________________
Other cancers Who? ____________________
Retardation/birth defects Who? ____________________
Endometriosis Who? ____________________
Alcoholism Who? ____________________
Osteoporosis Who? ____________________

FAMILY HISTORY CONTINUED:
Any other serious illnesses? If so, what and what? ____________________

Did you mother receive Stilbestrol (D.E.S.) while pregnant with you? ____________________

SOCIAL HISTORY:	YES	NO
Do you have a regular exercise program?	____	____
Have you ever smoked cigarettes?	____	____
Do you smoke now?	____	____
If so, how much daily? ________		
Do you use other recreational drugs?	____	____
Do you drink alcohol?	____	____
If so, how much daily? ________		
Are you currently having problems with your marriage or partner?	____	____
Do you wish to discuss any of the above answers?	____	____
Have you ever lived out of the United States?	____	____
Where? ________ When? ________		

QUESTIONS OR COMMENTS?

____
____
____
____

Thank you for filling out this lengthy, detailed questionnaire. It helps us a great deal.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that Tree of Life Birth and Gynecology, LLC uses electronic forms for communication, such as email, fax or text message. This method is secured whenever possible, but email or other electronic forms of communication, may not be secure and I have the right at any time to request that my personal health information is not communicated this way, by submitting a request in writing to the main office.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that all of my medical information will be recorded in a secure Electronic Health Records Database. This includes but is not limited to all of my completed health information and all current and ongoing Medical Records.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________ Date: __________

Relationship to Patient: ______________________

Signature: ______________________

Witness Printed Name: ______________ Signature: ______________

Patient Portal_Loop.zip

SeVocity
HEALTHCARE SOLUTIONS MADE EASY

Sevocity Secure Messaging Patient Portal

- The Sevocity Secure Messaging Patient Portal is a secure messaging system that may used with patients for items such as:
  - Requesting and confirming appointments
  - Requesting prescription refills
  - Patients sending questions concerning about their account
- The portal may also be used to send lab results and clinical summaries to patients, satisfying Meaningful Use requirement #13.
- The portal is optional. You can choose not to set up the portal at this time and can add it later. There is currently no additional charge for use of the Sevocity Patient Portal.
- If your website has a website, a link to the portal may be added to your website for your patients.

Suggested Patient Guidelines for Portal Use

If you elect to use the Sevocity Patient Portal you may want to give guidelines to your patients or have them sign an agreement in order to use the portal. Following are some items our customers recommend including in your agreement or notification to your customers.

Your User Name is: ____________________

Your initial password is: ____________________ (you will receive an email once we have set you up. Please click on the link to the portal and you will be asked to create a new password. Please remember your User Name and the Password you create. If you lose either one you will need to contact our office to have your portal reset.)

Participation

- Any current patient is eligible to participate in the Patient Portal. We will also provide a username and password to a patient who has made an appointment to be seen in the future.
- Privacy and Security
  - All messages sent to you will be encrypted.
  - Your email address is confidential and protected information. We will protect this information as we do your medical and other personal information.
  - We will never purposefully share this information with any third party.
  - Similar to phone communications, messages may be read and addressed by staff other than the physician staff.
  - When your physician is ill or on vacation, your emails will be addressed by a covering physician.
  - All access to our internal network and electronic medical records (EMR) is password protected.
  - Please read our HIPAA handout on privacy practices for information on how private health information is handled in our office.