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Welcome to our practice.

We want to take this opportunity to thank you for choosing

Westside OB/GYN Group, L.L.C. for you OB/GYN care needs.

Our practice strives to make every patient feel like a member of the family!

We answer our telephones on Monday and Wednesday from 8:30am to Noon and 1:30pm to 4:30pm, on Tuesday and Thursday from 7am to 3pm and on Friday from 7am until Noon. At all other times you can leave a message that will be returned promptly after we next open. One of our practitioners or covering providers is also available, on-call, to address urgent matters. Medication refills, laboratory and imaging results, forms and letters can only be addressed when the office is open.

We have privileges to treat our patients at Plantation General Hospital, Outpatient Surgical Services and Westside Regional Medical Center. (Please note that Westside Regional does not provide services for pregnant women).

We are fortunate to have Drs. Robert Bass, Marion Colas-Lacombe, Jaime Mercado and Maria Suescum-Diaz to help us care for you on weekends, holidays and when we are on vacation. You can expect the same level of care from them as you receive from us.

After your visit, you may receive a survey about your experience in our office. We value your input and look forward to hearing from you.

Once again, welcome to our practice.

PATIENT VISIT-COMPREHENSIVE HISTORY

Name:_____Age_____Date:_____

Primary Care Physician (PCP) Name:_____Did your PCP refer you to our office? Y N

What is the reason for your visit today? _____

_____

PERSONAL PAST HISTORY: (Please provide as much detail about **your** medical history as possible)

Diabetes	Yes	No
High Cholesterol (Including High Lipids/Triglycerides	Yes	No
Kidney disease	Yes	No
Urinary Infection	Yes	No
Neurologic Disease	Yes	No
Depression	Yes	No
Hepatitis	Yes	No
Thyroid disease	Yes	No
Domestic Violence	Yes	No
Asthma/TB	Yes	No
Breast Problem	Yes	No

High Blood Pressure	Yes	No
Heart Disease	Yes	No
Autoimmune Disorder (such as Lupus, Positive ANA)	Yes	No
Epilepsy/Seizures	Yes	No
Psychiatric illness	Yes	No
Liver Disease	Yes	No
Blood Clot in leg/lung	Yes	No
Trauma	Yes	No
Blood Transfusion	Yes	No
Seasonal Allergies	Yes	No
Infertility	Yes	No

Explanation: _____

_____

GYN Surgery . . . . Y N If yes, what type and when: _____

_____

_____

Other Surgery . . . . Y N If yes, what type and when: _____

_____

_____

_____

Have you been vaccinated for or had the following:

Chicken Pox	Yes	No	Measles	Yes	No	Mumps	Yes	No	German Measles	Yes	No
Hepatitis B	Yes	No	Tetanus	Yes	No	Diptheria	Yes	No	Pertussis	Yes	No
Polio	Yes	No									

GYN HISTORY: What was the first day of your last normal menstrual period?_____/_____/_____

Age of 1st menses_____yrs Have you received Gardasil or Cervarix Vaccine? Y N

How often do you get your period? Monthly Less than once a month More than once a month

Is your period heavy? Y N Do you pass clots with your period? Y N

What method of birth control do you currently use? (circle one or more) Abstinence Menopause Pills

Patch Ring Condom IUD Shot Tubes Tied Essure Vasectomy Timing Withdrawal Spermicide

Have you ever had an abnormal Pap Smear? Y N If so, when?_____ How was it treated? _____

Date of last Pap Smear?_____Normal? Y N Date of last mammogram?_____Normal? Y N

Date of last pelvic ultrasound (sonogram)?_____ Normal? Y N

Infection History:

Live with someone with TB	Yes	No		Gonorrhea (you or your partner)	Yes	No
Genital Herpes (you or your partner)	Yes	No		Chlamydia (you or your partner)	Yes	No
Rash or Viral Illness	Yes	No		HPV or Genital Warts (you or your partner)	Yes	No
Live with someone with Hepatitis B or C	Yes	No		Syphilis (you or your partner)	Yes	No
Any other Infectious Disease	Yes	No	Explain:			

OB HISTORY:

Total number of pregnancies in your life_____(please include miscarriages and pregnancy terminations)

Past Pregnancies (please list all pregnancies):

Delivery Date	Weeks of Pregnancy	Hours in Labor	Birth Weight	Sex of Baby	Type of Delivery	Anesthesia	Place of delivery	Complications

FAMILY HISTORY:

Mother: Alive? Y N Year of mother's birth? _____

Did/Does your mother have:

Alzheimer's Disease Birth Defects Blood Clot in Leg/Lung Breast Cancer Colon Cancer

Drug or Alcohol Problems Diabetes Heart Disease Hepatitis HIV High Cholesterol High Blood Pressure

Mental Illness Osteoporosis Ovarian Cancer Stroke Tuberculosis Uterine Cancer

Father: Alive? Y N Year of father's birth? _____

Did/Does your father have:

Alzheimer's Disease Birth Defects Blood Clot in Leg/Lung Breast Cancer Colon Cancer

Drug or Alcohol Problems Diabetes Heart Disease Hepatitis HIV High Cholesterol High Blood Pressure

Mental Illness Osteoporosis Prostate Cancer Stroke Tuberculosis

Others: (Circle all that apply to your other relatives: siblings, grandparents, aunts, uncles, cousins, etc.)

Alzheimer's Disease Birth Defects Blood Clots Breast Cancer Colon Cancer Drug or Alcohol Problems

Diabetes Heart Disease Hepatitis HIV High Cholesterol High Blood PressureMental Illness

Osteoporosis Prostate Cancer Stroke Tuberculosis Uterine Cancer

SOCIAL HISTORY:

Do you drink alcohol? Y N If so, how many drinks per day? _____

Do you smoke cigarettes? Y N If so, how many packs per day?_____If NO, have you ever smoked? Y N

Do you use another form of Tobacco (chewing tobacco, cigars, etc.)? Y N

Do you use any street drugs? Y N If so, what drug and how often? _____

Do you have sexual intercourse with: Men Women Both Nobody

Are you currently in a long-term mutually monogamous relationship? Y N

REVIEW OF SYSTEMS: (Please circle any of the following that you are currently experiencing)

Breast: lump or mass nipple discharge pain

Urinary: difficulty urinating blood in urine frequent urination incontinence (leaking)
awake to urinate at night pain with urination

Ear, Nose & Throat: runny nose cough hearing loss ringing in ears sore throat sores in mouth
sinus congestion

Cardiac: chest pain palpitations swelling of legs dizziness varicose veins

Respiratory: shortness of breath coughing wheezing pain with deep breathing

Eyes: diminished vision eye irritation drainage from eyes blurring of vision loss of vision

Neurologic: headache tingling/numbness seizures insomnia memory loss difficulty walking

Endocrine: excessive thirst excessive urination cold intolerance heat intolerance hot flashes hair loss

Skin: rash moles lumps dry or sensitive skin hives

Constitutional: weight gain loss of appetite fever weakness weight loss excessive fatigue

Gastrointestinal: nausea heartburn vomiting difficulty swallowing diarrhea constipation blood in stool

Skeletal: joint swelling joint pain leg cramps joint stiffness muscle pain/ache muscle weakness

Reproductive: heavy periods pain with intercourse pelvic pain pain with period
vaginal itching or burning abnormal vaginal discharge

Current Medications: Please list the name and dosage, including over the counter (such as Tylenol, Advil, Glucaosamine/Chondroitin, Etc.) and herbal products (such as Black Cohash, Gingko, Herbal Teas, Herbal Juices, etc.). (If you have a list, we will be happy to make a copy of it for our records so that you do not have to write it).

_____

_____

_____

_____

_____

Medication Allergies: ☐ None Known _____

_____

_____

Is there any information you think the doctor should have that you have not already written down?

_____

_____

_____

Patient Signature:_____ Date: _____

Name_____Social Security #_____Age _____

Birth Date_____ Driver's License #_____DL State _____

e-mail address:_____@_____

Home Phone #_____-_____-_____Cell Phone #_____-_____-_____Work Phone #_____-_____-_____

Marital Status [] S [] M []W [] D Religion:_____Primary Language [] English [] Other : _____

Street Address_____Apt # _____

City_____State_____Zip _____

Employer/School_____Title _____

Street Address_____City_____State_____Zip _____

Spouse_____Age_____Birthdate _____

Spouse Employer_____Title_____Phone # _____

Street Address_____City_____State_____Zip _____

Referred by:_____Primary Care Physician:_____

Person to contact in an emergency who does not live with you:

Name_____Phone #_____Relationship _____

Street Address_____City_____State_____Zip _____

Primary Insurance Information: Is this an employer plan? Y N

Company_____Insured's Name_____Insured's D.O.B. _____

Insured's SS #_____ID # _____Group # _____

Street Address_____City_____State_____Zip _____

Phone #_____-_____-_____Your relationship to insured [] Self [] Spouse [] Child [] Other

Secondary Insurance Information: Is this an employer plan? Y N

Company_____Insured's Name_____Insured's D.O.B. _____

Insured's SS #_____ID #_____Group # _____

Street Address_____City_____State_____Zip _____

Phone #_____-_____-_____Your relationship to insured [] Self [] Spouse [] Child [] Other

Guaranty of Payment: I fully understand that I am directly responsible for payment to Westside OB/GYN Group, L.L.C. for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collecting costs including reasonable attorney's fees in the event it becomes necessary to file suit for payment. I authorize payments to be made directly to Westside OB/GYN Group, L.L.C. Authorization to Release Information I hereby authorize Westside OB/GYN Group, L.L.C. to release any information acquired in the course of my visit or treatment to my insurance company for the purpose of processing any insurance claim. Assignment of Insurance Benefits If insurance claims are filed on my behalf, I hereby authorize direct payment of any benefits to Westside OB/GYN Group, L.L.C. for any treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of this authorization to be used in place of the original. In addition, I authorize Westside OB/GYN Group, L.L.C. to access records of my prescription medications directly from the pharmacy whenever it is deemed necessary for my care.

Signature_____Date _____

(parent if patient is a minor)

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

(Please note: you are not required to list any name if you do not so choose)

[] I do not wish my information to be released to anyone

I,_____, authorize Westside OB/GYN Group, L.L.C. to release or discuss information related to my medical condition (including information related to my treatment plan, medication, disease or diagnosis and/or billing information) to the following named persons (this negates all prior authorization):

1._____2. _____

3._____4. _____

Please list phone numbers where you would like us to contact you for:

• Results – Lab, Ultrasound, X-ray, Mammography, etc.

• Reminders for or changes of appointments

1. _____[] OK to leave detailed message/text

2. _____[] OK to leave detailed message/text

Patient's Name: _____

DOB:_____SS # _____

Date:_____Signature: _____