sacramento women's health
an ob/gyn partnership

2277 Fair Oaks Blvd, Suite 355 | Sacramento, CA 95825
phone 916.927.3178 fax 916.927.1488 sacwomenshealth.com

Welcome to Sacramento Women's Health.

Enclosed is your new patient packet. Please complete this paperwork and mail it back in the envelope provided. Please include a copy of your insurance card, front and back. Alternatively, you can bring the paperwork to your scheduled appointment.

Please bring your insurance card(s) and a photo ID with you to your visit

We are located on Fair Oaks Blvd between Howe Avenue and Fulton Avenue, next to the Pavilions Shopping Center. We are in the back building on the 2nd floor, near the elevator. Please call if you have any questions: (916) 927-3178.

We look forward to seeing you!

Thank you,

Office Staff
Sacramento Women's Health

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ACKNOWLEGMENT OF PATIENT PRIVACY PRACTICE NOTICE

I have been informed of Sacramento Women's Health Patient Privacy Practices. I am aware that this notice describes how medical information about patients may be used and disclosed and how I can get access to this information. I have been requested to review it carefully. I am aware that I have the right to a paper copy of this notice and may ask for a copy at any time. I may obtain a paper copy of this notice by asking a staff member at the front desk or writing to: Sacramento Women's Health 2277 Fair Oaks Blvd. Suite 355, Sacramento, CA 95825.

I am also aware that my Medical Record may be used in examination, testing, credentialing and/or certifying purposes by The American Board of Obstetrics and Gynecology.

Name-*please print* _____

_____ _____
Signature of patient date

I authorize Sacramento Women's Health to release medical information pertaining to my care with the following people other than myself. I will assume responsibility to notify Sacramento Women's Health, in writing, whenever this information changes.

Please think about listing the following people on this form:

- **Spouse/Parent/Significant other**
- **Person providing transportation to and from appointments**
- **Anyone you may ask to obtain appointment information**

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

_____ _____
Signature of patient Date

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Patient Information

Patient's Name _____Date of Birth _____

Address _____City _____State _____Zip_____

Home Phone _____ Cell _____ Marital Status S M W Div Sep

Email _____@_____ Work Phone _____

Occupation _____Social Security # _____

Employer _____

Spouse's Name _____ Date of Birth _____SS No _____

Race: ___Caucasian/white ___African American ___Chinese ___Filipino ___ English___ Spanish ___ Japanese
___ Korean ___ Vietnamese ___ Other Pacific Islander ___ Mexican ___ Other Spanish ___ Other _____
Interpreter needed ___yes ___ no

Primary Care Physician: _____ Medical Group_____

Person to Notify in Case of Emergency _____

Phone _____ Relationship _____

Pharmacy Preference _____

Address _____ Phone Number _____

Authorization for Assignment of Benefits and Information Release

I, the undersigned, authorize payment of medical benefits to Stephen Hiuga, MD, Laurie Gregg, MD, Mary Finegan MD, Judith Mikacich MD and/or Kathleen Rooney MD for any services furnished to me by the physicians. I understand I am financially responsible for any services not covered by my insurance. I further agree to pay reasonable attorney fees and court costs in the event that legal actions becomes necessary to enforce this contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date _____ Signed _____

Insurance Company _____ ID# _____

Insurance subscriber: ___Self ___Spouse ___Parent ___ other ___

Subscriber name: _____ Subscriber Date of Birth _____

Secondary Insurance _____ ID# _____

Insurance subscriber: ___Self ___Spouse ___Parent ___ other ___

Subscriber name: _____ Subscriber Date of Birth _____

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Patient History

Name _____ Date: _____
Marital/Partner Status: _____ How Long _____ Age: _____
How did you hear about our office? _____
Please answer the following questions that are pertinent to you to the best of your ability.

What is the main reason for your visit? _____

_____

Other issues you would like to address: _____
1. _____
2. _____
3. _____

Medical History

Do you have any allergies to medications? (Please list) _____

_____

Current Medications:

_____

_____

_____

Do you have or have you had any medical problems? (Please list)

Yes No

☐ ☐ Lung disorders including asthma: _____
☐ ☐ Heart disease or high blood pressure: _____
☐ ☐ Urinary tract disorders: _____
☐ ☐ Gastrointestinal disorders: _____
☐ ☐ Gynecological disorders: _____
☐ ☐ Endocrine disorders (diabetes, thyroid): _____
☐ ☐ Infectious diseases: _____
☐ ☐ Cancer: _____
☐ ☐ Psychiatric or neurological disorders: _____
☐ ☐ Other: _____

When was your last Pap smear test? _____
Have you ever had an abnormal Pap smear or HPV test? _____
Your last Mammogram? _____

Please list all surgeries with the approximate date: _____

_____

_____

_____

Please list any other hospitalizations with the reason and date: _____

_____

_____

_____

Social and Dietary History

Do you smoke? _____ If yes: number of cigarettes per day _____ Number of years_____

Do you drink alcohol? _____ If yes approximate number of glasses per week_____

Caffeine? ____ Cups per day ____ Do you use any illicit drugs or have you had any addictions in the past?_____

Are you currently in an abusive situation or have you been in one in the past?_____

Is your weight stable? _____ Do you follow a particular diet?_____

Do you take any vitamins or calcium?_____ Have you ever had an eating disorder? _____

Do you exercise regularly? _____ Have you had all your vaccinations? _____

Do you do monthly self-breast exams? If no, why? _____

Menstrual and Pregnancy History *(Use back of page if necessary)*

Menstrual

Date of last menstrual period _____ Age at first period_____

Are your periods regular? _____ How many days apart? _____

Do you take pain medications for cramps?_____ If so, what do you take?_____

Do you have hot flashes or night sweats? _____ If so how often? _____

Have you ever taken hormone medication? (List the medication and doses) _____

_____

Pregnancy

How many pregnancies? _____ Number of vaginal deliveries _____

Number of cesarean sections_____ Number of miscarriages_____

Number of abortions _____

Are you currently trying to get pregnant?_____ If so, how long have you tried?_____

Have you ever had an infertility evaluation?_____ If so, when and what was done?_____

What form of birth control do you use now? _____

What types if any have you tried in the past? Complications?_____

_____

Are you sexually active? _____

Any possible exposures to a sexually transmitted disease? _____

Would you like to be tested for a sexually transmitted disease? _____

Family History

Please check any diseases that a member of your family has been affected by, and list which members were affected and their age at diagnosis.

☐ Hypertension _____ ☐ Osteoporosis _____

☐ Lupus_____ ☐ Heart Disease _____

☐ Arthritis _____ ☐ Alzheimer's _____

☐ Diabetes _____ ☐ Parkinson's Disease _____

☐ Intestinal Disease _____ ☐ Birth Defects _____

☐ Cancer (please indicate type) _____ ☐ Genetic Disorders _____

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If you would like to hear about office news and information important to women's health please provide us with your email address. Your address will not be used for anything other than to send you information and you will be able to stop the email at any time.

Patient name: _____

Date of birth: _____

E-mail address: _____
(Please print)