PATIENT HISTORY Name: **Date of Birth:**

Personal History of Past Illness

Major Illness	Yes (Date)	Major Illness	Yes (Date)
Anemia		Glaucoma	
Arthritis/Joint pain		Headaches (chronic only)	
Asthma		Heart Disease	
Back problems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clots in lungs or legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken bones		Kidney Infections/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcers	
Chickenpox		Rheumatic Fever	
Collagen Vascular Disease (Lupus)		Seizures/Convulsions/Epilepsy	
Depression or Anxiety (circle)		Sexually Transmitted Disease	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN History

Problem	Yes	No	Problem	Yes	No
Abnormal hair growth			Infertility		
Abnormal Bleeding			Ovarian Cyst		
Abnormal Pap Smear			Osteoporosis		
Breast Problems			Sexual Problems		
Cyst of Vulva			Sexually transmitted disease		
DES Exposure			Uterine Abnormality		
Endometriosis			Urinary Leakage		
Fibroid Uterus			Vaginal/Vulvar Infection		

Surgeries

Surgery	Yes	No	Date/Comments
Abdominal Surgery			
C-Section Delivery			
Dilation & Curettage (D & C)			
Hysterectomy			
Hysteroscopy (out patient)			
Laparoscopy (out patient)			
Vaginal Surgery			
Bartholin Glands Surgery			

Other (Please List):

Social History

Preferred Name:	PCP:	Occupation:
Number of people in household:	Single Married Widowed Divorced Separated Living w/ partner	
Education (last grade completed):	Name of significant other:	
Children's Names:		
Seat Belt Use: Always Frequently Occasionally Never		
Occupational Risks: None Biohazard Chemical Physical Labor		
How many days per week do you exercise?	How many packs of cigarettes per day do you smoke?	
How many times per week do you drink alcohol?		
Do you use any of the following? cocaine narcotics marijuana hallucinogens		

Family History- Please check those that apply

Illness	Mother	Father	Sibling	Child	Maternal Grandparent	Paternal Grandparent	Other
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Alzheimer's Disease							
Birth Defects							
Blood Clots in lungs or legs							
Diabetes							
Drinking or Drug problems							
Endometriosis							
Fibroids							
Heart Disease							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV/AIDS							
Mental Illness/Depression							
Osteoporosis							
Stroke							
Tuberculosis							
Other							

Obstetric History

#Total Pregnancies		#Full Term		#Premature		#Elective Abortion	
# Miscarriage		#Ectopic		#Multiples		#Living	

Pregnancy #	1	2	3	4	5	6
Pregnancy Outcome F=Full term, P=Premature, M=Miscarriage						
Delivery Date						
Weeks at Delivery						
Length of labor (hrs.)						
Epidural/Anesthesia						
Delivery Type V=Vaginal, C=C-section						
Did you have Pre-term Labor?						
Delivery Location						
Who delivered your baby?						
Baby weight?						
Baby Sex?						
Baby Name?						
Complications	Please check any that apply					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Post partum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complications						

Athens Obstetrics & Gynecology
740 Prince Avenue, Athens, GA 30606

AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT FOR DISCLOSURE TO FAMILY MEMBER(S) AND/OR PERSONAL REPRESENTATIVE

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____ _____ _____ _____
and Street City State Zip

I agree to allow Athens Obstetrics & Gynecology to release personal health information to my insurance company for purposes of payment and to other physicians for the purposes of continuation of care.

I have agreed to let certain other individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Athens Obstetrics and Gynecology, Dr. _____ and his/her staff to disclose my personal medical information to the following individual(s): I understand that I may revoke this consent at any time by written notice to the practice.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CONDITIONS FOR DISCLOSURE (Check the item(s) that apply):

_____ The practice may disclose my personal health information to the individual(s) above **only in my presence**

_____ The practice may disclose my personal health information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures bv telephone, fax, email or regular mail.

_____ Other conditions of disclosure: _____

_____ I **DO NOT** wish to allow access to my information to anyone (other than as stated above for further treatment or payment purposes to other physicians or my insurance company.)

Patient signature: _____ Date: _____

Witness: _____ Position: _____

Printed name of witness: _____

ATHENS OBSTETRICS & GYNECOLOGY, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF

PRIVACY PRACTICES

Patient Name_____ Account #_____

I understand that I can request restriction on how my health information is used or disclosed to carry out treatment or health care operation. However, there may be times when Athens Obstetrics and Gynecology, LLC is not able to honor my request restrictions. For example, they may need to release my medical information to get paid from an insurance company or to treat me.

I consent to the disclosure of my protected health information for the purpose of medical diagnosis, providing treatment, obtaining payment, or to conduct necessary health care operation, and authorize direct payment of medical insurance benefits to Athens Obstetrics and Gynecology, LLC for services performed. I also understand and agree that I am responsible for payment of all valid charges not paid by my medical insurance.

I accept that there is no guarantee of protection of my medical record from a court order release. In the event of legal proceedings involving patient care, I understand the contents of my file must be made available to legal counsel representing the practice and professional employee.

I have received a copy of Athens Obstetrics and Gynecology, LLC Notice of Privacy Practices on the date listed below, and have been advised that I will be notified of any changes at future office visits. I may obtain a current copy by visiting the Web site www.AWHG.yourmd.com.

_____ _____

Signature of Patient or Personal Rep Date

_____

Print Name of Patient or Personal Rep

_____

Personal Representatives Authority