Babycatchers Patient Information Sheet

Please print clearly

Last Name	First Name	Middle Name
Address:	City	State / Zip Code:
Text Authorized: Yes No		
Primary Phone:	Secondary Phone:	Work Phone:
Patient's Gender Female Male	Date of Birth:	Marital Status: M S W D SEP
Patient SS#	Patient Employer	Occupation:
Spouse SS#	Spouse Name	Date of Birth:
Pharmacy Name/Phone:	Race:	Ethnicity:
Emergency Contact/Phone/Relationship:		
Email Address:		

Patient Consent for Use and Disclosure Protected Health Information

By signing this consent, I consent Dr. Phoebe Ho and her providers to use and disclose protected health information (PHI) about me, to carry out treatment, payment and healthcare operations (TPO). Please refer to *Notice of Privacy Practice* for a more complete description of such uses and disclosures. I have the right to review the *Notice of Privacy Practice* prior to signing this consent. Dr. Phoebe Ho reserves the right to revise its *Notice of Privacy* at anytime. You may request a revised copy at any time.

I consent to having the clinic staff and providers call my home or other designated location and leave a message on voice mail or with a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to clinical care including lab results. I consent to having mail come to my home or other designated location that will assist in carrying out TPO, such as appointment reminder cards and patient statements. I consent to having emails that I specifically authorize come to my listed email address. I understand that it is my responsibility to make sure that the information is being received on a secured line.

By signing is form, I am consenting for Phoebe Ho, MD and her providers to use and disclose my PHI to carry out TPO for the period of **one-year** from the date of this signing. I have the right to revoke my consent **in writing** except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that by not signing this consent, Phoebe Ho and her providers may decline to provider treatment at their discretion.

I authorize payment for services to Phoebe Ho MD, PLLC; however I understand that I am fully responsible for payment of care I receive.

Signature____ Date___________________________

PATIENT HISTORY

Date: ____________ Name: ____________________ DOB: _____________________ Age: __________
ALLERGIES: ____ Occupation: __________________________

What are you being seen for today?

____

____

First day of last period __________ (best guess ok) Are your periods regular? Y / N Bleeding: Heavy, moderate, light
Last PAP: __________(best guess ok) Ever had an abnormal PAP: Y / N Treated for Abnormal PAP (When) _____________
# of Pregnancies ______ # of Abortions ______ # of Miscarriages _______ # of Lives births ______
Last Mammogram: _______________ (best guess ok) Current birth control method: ___________________________

Current Medications:

____

Vitamins/Supplements:

____

Medical History:
Do you currently have or previously had any of the following (please circle)

YES NO High Blood Pressure
YES NO Epilepsy
YES NO Frequent Headaches/Migraines
YES NO Stroke
YES NO Heart Disease/Heart Murmur
YES NO Asthma
YES NO Thyroid Disease
YES NO Diabetes
YES NO Liver Disease
YES NO Chronic Constipation/Diarrhea
YES NO Frequent Bladder Infections
YES NO Kidney Disease
YES NO STD's: Herpes, Gonorrhea, Chlamydia, Genital Warts, Syphilis, HIV
YES NO Osteoporosis
YES NO Unintended Leaking of Urine
YES NO Mental health Disorders (depression, bipolar disease, etc.)

List any Surgeries/Operations (Please include Year, Type of surgery, Doctor and Hospital)

____

____

Family History: (please list who)
YES NO Diabetes: _______________
YES NO Heart Disease: ____________
YES NO High Blood Pressure: _______
YES NO Cancer: ________________
YES NO Stroke: _____________
YES NO Thyroid Disease: _____________

Social History:
YES NO Do you smoke? How much? __________
YES NO Do you drink alcohol? How Often? __________
YES NO Do you/have you used street drugs?
Which ones? __________________________
Who Do you live with? _______________
YES NO Do you feel safe in your home?

REVIEW OF SYMPTOMS

Please tell us if you are **CURRENTLY** experiencing any of the following symptoms. Circle all that apply.

Constitutional:	**Breast:**	**Cardiovascular:**	**Respiratory:**
Fatigue Fever Chills	Lumps Nipple Discharge Abnormal changes in breast size	Chest Pain Irregular heart beats Varicosities	Shortness of Breath Wheezing Cough TB Exposure
Gastrointestinal: Nausea Vomiting Diarrhea Constipation Loss of appetite Bloody stools	**Genitourinary:** Urgency Frequency Painful Urination Incontinence Genital sores Irregular periods Painful periods Heavy vaginal bleeding Change in vaginal discharge Post-Coital bleeding Amenorrhea	**Skin:** Hair Growth change New skin lesions Changes to existing skin lesions or moles	**Neurologic:** **Muscular weakness** **Memory difficulties** **seizures**
Endorine: Galactorrhea (Milky discharge from nipples) Cold Intolerance Unexplained weight loss	**Psychiatric:** Anxiety Depression Suicidal thoughts	**Lymphatic:** Easy bleeding Easy Bruising Lymph Node enlargement or tenderness	

Additional Comment:____

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Patient Signature:____________________________ Date:______________