



Women's Care of Alaska

2741 Debarr Rd, Suite C-205  
Anchorage, AK 99508  
(907) 279-2273 \* Fax (907) 258-7705

Wynd Counts, MD  
Wendy Cruz, MD  
Kristina Eaton, MD  
Allison van Haastert, MD  
Jessica Goldberger, MD

Katie Ulmer, ANP  
Migel Hadley, ANP  
Winifred Koehler, ANP

**PATIENT:**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Preferred Ph# \_\_\_\_\_ Other # \_\_\_\_\_ Email \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship Status \_\_\_\_\_ Gender Identity \_\_\_\_\_ Sexual Orientation \_\_\_\_\_  
Race \_\_\_\_\_ Ethnicity \_\_\_\_\_  
How did you hear about our practice? \_\_\_\_\_

**PARTNER:**

Partner Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Preferred Ph# \_\_\_\_\_ Other # \_\_\_\_\_ Email \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**IF PATIENT IS A MINOR**

Who may authorize treatment? \_\_\_\_\_ Relationship \_\_\_\_\_ Contact#: \_\_\_\_\_

**INSURANCE:**

**PRIMARY INSURANCE COMPANY:**

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employment Status \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:**

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employment Status \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**EMERGENCY CONTACT:**

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph# \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph# \_\_\_\_\_

**AUTHORIZATION** Please initial each line, and sign the bottom

- \_\_\_\_ I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care.  
\_\_\_\_ I authorize direct payment to the provider(s) for my medical and/or surgical care.  
\_\_\_\_ I understand that I am responsible to pay any non-covered charges or services.  
\_\_\_\_ I understand that if I am uninsured, I am responsible to pay for any services provided.  
\_\_\_\_ I have read and agree to the PATIENT FINANCIAL POLICY for Women's Care of Alaska.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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## PATIENT PORTAL

In the Summer of 2018, we launched our online Patient Portal with [www.myhealthrecords.com](http://www.myhealthrecords.com). The implementation of this new system allows us to send automated appointment reminders / messages. Please provide your most current information below, so what we may ensure timely and accurate delivery of appointment reminders/messages:

### CURRENT EMAIL ADDRESS:

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### PREFERRED PHONE NUMBER FOR CONTACT:

Home \* Mobile \* Business

(\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

### PREFERRED METHOD TO RECEIVE REMINDERS/ MESSAGES

*( Please ONLY circle the ways you wish to receive all your appointment reminders/messages.)*

**Voice Call \* Text \* Email\* Do Not Contact for Reminders**

Additionally, the Patient Portal will allow you the ability to request appointments, directly and securely message your provider, view your medical records, and much more. Activating your Patient Portal is simple. We will send you an email invitation, simply follow the instructions in the email to set up your Patient Portal Account.

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Patient Printed Name

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Date

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Patient Signature

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## CONSENT TO TREAT and PAYMENT RESPONSIBILITY

The undersigned consents to medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to, laboratory procedures, ultrasounds, medical or surgical treatment, or procedures, or other services rendered to the patient under the general and special instructions of the physician or provider.

The undersigned understands that Women's Care of Alaska (WCAK) has agreed to bill my insurance as a courtesy. In order to process such payments and obtain procedure authorizations, WCAK may disclose any or all my medical record to medical service companies, insurance companies, or workman's compensation carriers, as necessary. The undersigned authorizes all insurance carriers, with whom I have coverage, including Medicare, Medicaid, and Tricare, to assign all payment of benefits due under the terms of my policy, to Women's Care of Alaska, including any settlements or judgments for such items or services. The undersigned agrees to notify WCAK of any changes in my insurance coverage, as soon as possible, to ensure there is no delay in billing. If, for some reason, my health insurance sends payment directly to me, I agree to immediately forward all payments that I have received for my care, and treatment, to WCAK. I understand and agree that I have been advised that I may be billed by WCAK and that this Assignment of Benefits and Agreement to Pay applies to any and all WCAK physician services, including both inpatient and outpatient charges, performed by my provider.

The undersigned understands that some items or services provided may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services in excess of the limits in my member benefit agreement. I understand that I am personally responsible for any item or service determined by my insurance company to be experimental, investigational, or to be non-covered for any other reason. I understand that I am personally responsible for any non-covered Medicare, Medicaid, Tricare items or services that are listed on the financial responsibility for non-covered items or services form. I am responsible for all copays, deductibles, and coinsurance established by my member benefit agreement.

The undersigned understands and agrees that all account balances are **due within 30 days of billing**. I also understand that if my account becomes delinquent, the account will be referred to an outside collection agency for payment resolution. If my account is referred to an outside collection agency, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process.

\_\_\_\_\_  
(Printed Name of Patient, Parent, or Guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient, Parent, Guardian Signature:

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### PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_  
Month Day Year

#### AUTHORIZED METHODS OF COMMUNICATION (✓ Check all that apply)

| <input type="checkbox"/> RESIDENCE TELEPHONE                                      | <input type="checkbox"/> CELL PHONE                                               | <input type="checkbox"/> WORK TELEPHONE                                           |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Number: (    ) _____                                                              | Number: (    ) _____                                                              | Number: (    ) _____                                                              |
| <input type="checkbox"/> Leave a call back number only.<br>Do NOT leave a message | <input type="checkbox"/> Leave a call back number only;<br>Do NOT leave a message | <input type="checkbox"/> Leave a call back number only;<br>Do NOT leave a message |
| <input type="checkbox"/> OK to leave detailed<br>message with person              | <input type="checkbox"/> OK to leave detailed<br>message with person              | <input type="checkbox"/> OK to leave detailed<br>message with person              |
| <input type="checkbox"/> OK to leave detailed<br>message on voicemail             | <input type="checkbox"/> OK to leave detailed<br>message on voicemail             | <input type="checkbox"/> OK to leave detailed<br>message on voicemail             |

Do you authorize us to speak with another individual, such as a spouse/partner, or other relative, regarding your PHI? If so, please write their name down below, along with their relationship to you. This information can be changed any time you request a change. Forms of PHI include, but are not limited to, the following examples:

#### (T) Treatment

Test results  
Prescriptions/refills  
Treatment Options

#### (P) Payment

Insurance questions/problems  
Account balance/payment options

#### (O) Healthcare Operations Activities

Appointment reminder, Messages returned  
Referral options/appointments, Records release  
Messages that results are available

Name: \_\_\_\_\_ / \_\_\_\_\_  
PLEASE PRINT (RELATION TO PATIENT)

(T) (P) (O) Circle all that apply

Name: \_\_\_\_\_ / \_\_\_\_\_  
PLEASE PRINT (RELATION TO PATIENT)

(T) (P) (O) Circle all that apply

Name: \_\_\_\_\_ / \_\_\_\_\_  
PLEASE PRINT (RELATION TO PATIENT)

(T) (P) (O) Circle all that apply

Name: \_\_\_\_\_ / \_\_\_\_\_  
PLEASE PRINT (RELATION TO PATIENT)

(T) (P) (O) Circle all that apply

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



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### **INFORMED CONSENT – TELEMEDICINE APPOINTMENT**

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through use of interactive video, audio, or other telecommunication technology. Additionally, a physical examination of you may take place, and video, audio and/or photo recordings may be taken.

#### **ANTICIPATED BENEFITS:**

- Improved access to medical care by enabling a patient to remain in their location while the healthcare provider provides care from a distant site.
- Limiting the spread of COVID-19.
- More efficient medical evaluation and management.

#### **POSSIBLE RISKS:**

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- It may be determined that that information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation / treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all your medical records may result in adverse drug reactions or allergic reactions or other judgment errors.

#### **BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:**

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
- I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed without my authorization.
- I understand that during the COVID-19 Pandemic, security measurements may be lessened in accordance with U.S. Department of Health and Human Services to ensure improved access to care.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time without affecting my right to future care or treatment.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
- I understand that certain fees for service may be waived during the COVID-19 Pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I understand that I am still responsible for any co-payments or co-insurance that may apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost(s), I will be responsible for payment.

I have read and understand the information provided above regarding telemedicine. I hereby authorize the use of Telemedicine in the course of my diagnosis and treatment.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

What brings you to our office today? \_\_\_\_\_

If we need to contact you, regarding any future appointments or to give you test results, may we leave a message?

☐ Yes ☐ No Please specify the preferred phone number: (\_\_\_\_) \_\_\_\_\_

## ALLERGIES

| LIST DRUG, ENVIRONMENTAL AND FOOD ALLERGIES | REACTION |
|---------------------------------------------|----------|
|                                             |          |
|                                             |          |
|                                             |          |

## CURRENT MEDICATIONS

| DRUG NAME | DOSE | DRUG NAME | DOSE |
|-----------|------|-----------|------|
|           |      |           |      |
|           |      |           |      |
|           |      |           |      |

## GYN HISTORY | ANNUAL UPDATE

☐ N/A – I no longer have a period. Age when periods stopped: \_\_\_\_\_

**\*\* If you answered N/A above – Skip this section.\*\***

Date last menstrual period began: \_\_\_\_\_ Menstrual cycles are: ☐ Regular ☐ Irregular

Age when periods started: \_\_\_\_\_ Menstrual bleeding is: ☐ Light ☐ Moderate ☐ Heavy Periods last: \_\_\_\_\_ days

Cramps are: ☐ Mild ☐ Moderate ☐ Severe ☐ N/A Cramps last: \_\_\_\_\_ days

Spotting occurs between periods: ☐ Yes ☐ No Spotting Occurs after intercourse: ☐ Yes ☐ No

## EXAM HISTORY

Date of last dental exam: \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ ☐ Normal ☐ Abnormal Date of last PAP: \_\_\_\_\_ ☐ Normal ☐ Abnormal

Date of last colon screening: \_\_\_\_\_ ☐ Normal ☐ Abnormal

## STD HISTORY

☐ N/A – Have never been tested/treated for any sexually transmitted diseases.

Have you ever been treated for any of the following conditions: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ PID

☐ Herpes ☐ Trichomonas Have you ever been tested for HIV: ☐ Yes ☐ No

## SEXUAL HISTORY

☐ N/A – Have never been sexually active.

Are you currently sexually active? ☐ Yes ☐ No - Males ☐ Females ☐ Both ☐

Did you begin sexual activity before 16 y/o? ☐ Yes ☐ No

If yes, what age started? \_\_\_\_\_

Have you had > 5 sexual partners in your lifetime? ☐ Yes ☐ No

If yes, how many? \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**CONTRACEPTION** ☐ N/A – Not currently using any form of birth control.

|                                      |                                       |                                              |                                         |                                     |
|--------------------------------------|---------------------------------------|----------------------------------------------|-----------------------------------------|-------------------------------------|
| <b>Current Birth Control Method:</b> | <input type="checkbox"/> Condoms      | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Vasectomy  |
|                                      | <input type="checkbox"/> Depo Provera | <input type="checkbox"/> Natural / Rhythm    | <input type="checkbox"/> IUD            | <input type="checkbox"/> Nexplanon® |
|                                      | <input type="checkbox"/> Other _____  |                                              |                                         |                                     |

**PREGNANCY HISTORY** ☐ N/A – No changes since last visit.

|                                |  |                             |  |                              |  |
|--------------------------------|--|-----------------------------|--|------------------------------|--|
| Total number of times pregnant |  | Number of Cesarean Sections |  | Number of miscarriages       |  |
| Number of full-term deliveries |  | Number of living children   |  | Number of elective abortions |  |

**PERSONAL MEDICAL HISTORY** ☐ N/A – No changes since last visit.

| YES | CONDITION           | YES | CONDITION                | YES | CONDITION         |
|-----|---------------------|-----|--------------------------|-----|-------------------|
|     | Diabetes            |     | Heart disease            |     | Anxiety           |
|     | High Blood Pressure |     | Hepatitis                |     | Seizures          |
|     | GI Reflux Disease   |     | Liver Problems           |     | Asthma            |
|     | Other GI Disease    |     | Kidney Infections/stones |     | Lung Disease      |
|     | Fibroids            |     | Arthritis                |     | Tuberculosis      |
|     | Endometriosis       |     | Joint Pain               |     | Thyroid Disease   |
|     | Osteopenia          |     | Fracture                 |     | Clotting Disorder |
|     | Osteoporosis        |     | PCOS                     |     | Ovarian Cyst      |
|     | Cancer (type)       |     | Migraine                 |     | Other             |
|     | High Cholesterol    |     | Depression               |     |                   |

**SURGICAL HISTORY** ☐ N/A – No changes since last visit.

| SURGERY | YEAR | SURGERY | YEAR |
|---------|------|---------|------|
|         |      |         |      |
|         |      |         |      |
|         |      |         |      |

**FAMILY HISTORY** ☐ N/A – No changes since last visit.

| CONDITION           | YES | RELATION | CONDITION                | YES | RELATION | CONDITION         | YES | RELATION |
|---------------------|-----|----------|--------------------------|-----|----------|-------------------|-----|----------|
| Diabetes            |     |          | Heart Disease            |     |          | Depression        |     |          |
| High Blood Pressure |     |          | High Cholesterol         |     |          | Lung Disease      |     |          |
| GI Reflux           |     |          | Liver Problem            |     |          | Asthma            |     |          |
| Fibroids            |     |          | Kidney Infections/Stones |     |          | Tuberculosis      |     |          |
| Endometriosis       |     |          | Arthritis                |     |          | Thyroid Disease   |     |          |
| Osteopenia          |     |          | Cancer - Type:           |     |          | Clotting Disorder |     |          |
| Osteoporosis        |     |          | Joint Pain               |     |          | Other             |     |          |

**SOCIAL HISTORY | HABITS | PERSONAL SAFETY**

Special Diet? ☐ Yes ☐ No Type: \_\_\_\_\_

Do you exercise? ☐ Never ☐ Rarely (1-2x/yr) ☐ Occasionally (1-2x/month) ☐ Often (1-2x/wk) ☐ Regularly (3-5x/wk)

Smoking: ☐ Yes ☐ No ☐ Former Packs/day: \_\_\_\_\_ Number of years: \_\_\_\_\_ Quit Date: \_\_\_\_\_

Alcohol: ☐ Yes ☐ No ☐ Former Drinks/day: \_\_\_\_\_ Drinks per week: \_\_\_\_\_ Quit Date: \_\_\_\_\_

Drug Use: ☐ Yes ☐ No ☐ Former Type: \_\_\_\_\_ Number of Years? \_\_\_\_\_ Quit Date: \_\_\_\_\_

Caffeine: ☐ Yes ☐ No # Of cups per day: \_\_\_\_\_ Cups per week: \_\_\_\_\_

Has anyone close to you, ever threatened to, or physically hurt you? ☐ Yes ☐ No

Has anyone, including your partner, ever forced you to have sex? ☐ Yes ☐ No

Do you fear harm from anyone at home, or school, or anywhere else? ☐ Yes ☐ No

Do you have any concerns about your body image? ☐ Yes ☐ No

PATIENT NAME: \_\_\_\_\_

## REVIEW OF SYSTEMS

Please check **ONLY** those conditions, that you are **CURRENTLY** experiencing

| CONSTITUTIONAL             | YES | NOTES | GENITOURINARY             | YES | NOTES |
|----------------------------|-----|-------|---------------------------|-----|-------|
| Fever                      |     |       | Abnormal Bleeding         |     |       |
| Chills                     |     |       | Vaginal Discharge/odor    |     |       |
| Fatigue                    |     |       | Vaginal Itching/burning   |     |       |
| Weight Loss                |     |       | Pelvic Pain               |     |       |
| Weight Gain                |     |       | Menstrual Cramps          |     |       |
| <b>EYES</b>                |     |       | Painful Intercourse       |     |       |
| Change in Vision           |     |       | Genital Lump              |     |       |
| Double Vision              |     |       | Fertility Concerns        |     |       |
| <b>HEENT</b>               |     |       | Menopausal Concerns       |     |       |
| Earaches                   |     |       | <b>MUSCULOSKELETAL</b>    |     |       |
| Ringing in ears            |     |       | Muscle Weakness           |     |       |
| Sinus Problems             |     |       | Joint Stiffness           |     |       |
| Sore Throat                |     |       | Joint Pain                |     |       |
| Mouth Sores                |     |       | Joint Swelling            |     |       |
| Dry Mouth                  |     |       | <b>SKIN/BREAST</b>        |     |       |
| <b>CARDIOVASCULAR</b>      |     |       | Breast Pain               |     |       |
| Chest Pain                 |     |       | Nipple Discharge          |     |       |
| Diff. breathing w/exertion |     |       | Breast Lumps              |     |       |
| Swelling of legs           |     |       | Rash                      |     |       |
| Palpitations               |     |       | Ulcers                    |     |       |
| Heart Murmurs              |     |       | <b>PSYCHIATRIC</b>        |     |       |
| <b>RESPIRATORY</b>         |     |       | Depression                |     |       |
| Wheezing                   |     |       | Mood Swings               |     |       |
| Spitting up blood          |     |       | Anxiety                   |     |       |
| Shortness of Breath        |     |       | Suicidal Thoughts         |     |       |
| Cough                      |     |       | Homicidal Thoughts        |     |       |
| <b>GASTROINTESTINAL</b>    |     |       | <b>ENDOCRINE</b>          |     |       |
| Diarrhea                   |     |       | Abnormal Thirst           |     |       |
| Constipation               |     |       | Hot Flashes               |     |       |
| Nausea/vomiting            |     |       | Tremors                   |     |       |
| Bloody Stool               |     |       | Cold/Heat Intolerance     |     |       |
| Abdominal Pain             |     |       | <b>HEMATOLOGIC</b>        |     |       |
| Indigestion                |     |       | Frequent Bruising         |     |       |
| Bloating                   |     |       | Cuts do not stop bleeding |     |       |
| Liver Problem/Hepatitis    |     |       | Enlarged Lymph nodes      |     |       |
| <b>GENITOURINARY</b>       |     |       | <b>OTHER</b>              |     |       |
| Blood in Urine             |     |       |                           |     |       |
| Pain with Urination        |     |       |                           |     |       |
| Urgency                    |     |       |                           |     |       |
| Urinary Incontinence       |     |       |                           |     |       |
| Urinary Frequency          |     |       |                           |     |       |



# Family History Questionnaire for Common Hereditary Cancer Syndromes

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Age of First Period:** \_\_\_\_\_ **Your Age When First Child Delivered (If applicable):** \_\_\_\_\_ **Age of Your Mother:** \_\_\_\_\_  
**Are you Menopausal:** \_\_\_\_\_ **Have you ever used hormone replacement therapy? Please circle **Yes** or **No** If Yes, how long have you been it?** \_\_\_\_\_  
**Has anyone in your family had genetic testing for hereditary cancer syndrome (Ex: BRCA or LYNCH)? Please circle **Yes** or **No** If Yes, what was the result?** \_\_\_\_\_  
**Best Contact Phone Number(s):** \_\_\_\_\_ **Email:** \_\_\_\_\_

Please mark below if there is a **personal or family history** of any of the following cancer and **indicate family relationship** and **their AGE at diagnosis** in the appropriate column. Consider parents, children, siblings, grandparents, aunts, uncles, and cousins.

| Please Check |   |                                                                                                                                    | You (age at diagnosis) | Siblings/Children (Who + age at diagnosis)<br>Ex: Brother, 36 yrs | Your Mother's side (Who + age at diagnosis)<br>Ex: Aunt, 44 yrs | Your father's side (Who + age at diagnosis)<br>Ex: Grandpa, 65 yrs |
|--------------|---|------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------|
| Y            | N | Breast cancer                                                                                                                      |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Breast cancer in both breasts or multiple primary breast cancers                                                                   |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Ovarian cancer                                                                                                                     |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Male breast cancer                                                                                                                 |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Are you of Ashkenazi Jewish descent                                                                                                |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Uterine (endometrial) cancer (NOTE: do not include cervical cancer)                                                                |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Colon cancer                                                                                                                       |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Stomach, kidney/urinary tract, brain, or small bowel/intestinal cancer (NOTE: Please circle or write appropriate cancer in column) |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | 10 or more colon polyps found in a lifetime                                                                                        |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Prostate cancer                                                                                                                    |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Pancreatic cancer (Col/BRCA)                                                                                                       |                        |                                                                   |                                                                 |                                                                    |
| Y            | N | Malignant melanoma                                                                                                                 |                        |                                                                   |                                                                 |                                                                    |

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For Office Use Only

BRCA/Lynch/myRisk Testing Indicated? **Yes** **No**  
 Patient offered hereditary cancer testing? **Yes** **No** If YES: **ACCEPTED** **DECLINED:** \_\_\_\_\_  
 Follow-up appointment scheduled? **Yes** **No** Date of Appointment: \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>BRCA - Personal or Fam History</b><br>One person with (out to 2nd degree) <ul style="list-style-type: none"> <li>Breast cancer at 45 or younger</li> <li>Ovarian cancer at any age</li> <li>Male breast cancer at any age</li> <li>Breast cancer + Jewish Heritage</li> <li>Bilateral Breast cancer at 50 or younger</li> <li>Triple negative breast cancer at any age</li> <li>Family history of known BRCA1 or BRCA2 mutations</li> </ul> | <b>BRCA - Personal or Fam History</b><br>Two persons with (out to 3rd degree) <ul style="list-style-type: none"> <li>2 breast cancers w/ 1 ≤ 50 yrs</li> <li>Breast &amp; ovarian cancer (any age)</li> </ul> Three persons with (out to 3rd degree) <ul style="list-style-type: none"> <li>Breast and/or Ovarian and/or Pancreatic (any age) and/or aggressive prostate cancer</li> </ul> | <b>Lynch Syndrome (Colon/Endometrial)</b><br>Personally affected with: <ul style="list-style-type: none"> <li>Colon and/or Endometrial cancer at ≤ 50 yrs</li> <li>Family history of known Lynch mutations</li> </ul> Family History of Colon, Endometrial, or Lynch Cancers (out to 2nd degree) (ie. Gastric, ovarian, brain, kidney, small bowel) <ul style="list-style-type: none"> <li>1 or more Lynch cancers, 1 dx ≤ 50 yrs</li> </ul> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



## OBSTETRIC MEDICAL HISTORY

Wynd Counts, MD \* Wendy Cruz, MD \* Kristina Eaton, MD

Allison van Haastert, MD \* Jessica Goldberger, MD

Name:

LAST

FIRST

MIDDLE

Date Form Completed:      -      -

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

### Personal Health History

1. ☐ Yes ☐ No

Have you ever had an allergic reaction to a medication or vaccine component?

If yes, please list: \_\_\_\_\_

Any other allergies or reactions? \_\_\_\_\_

2.

Please mark any condition that you have or have had in the past:

☐ Epilepsy

☐ Anemia

☐ Recurrent Urinary  
Tract Infections

☐ Sexually Transmitted  
Infections

☐ Headaches

☐ von Willebrand disease or  
other bleeding disorders

☐ Gestational Diabetes

☐ HIV/AIDS

☐ Thyroid Disorder

☐ Blood Clotting Disorder  
(eg, Phlebitis/Thrombophilia)

☐ Diabetes (Type 1 or Type 2)

☐ Frequent Infections

☐ Breast Disease

☐ Blood Transfusion

☐ Arthritis or Lupus

☐ Psychiatric Illness

☐ Asthma

☐ Gastrointestinal Illness

☐ Skin Disorders

☐ Depression/Postpartum  
Depression

☐ Tuberculosis

☐ Hepatitis

☐ Prior Preterm Birth

☐ Eating Disorder

☐ Heart Disease

☐ Kidney Disease

☐ Group B Streptococcus In  
Prior Pregnancy

☐ Other: \_\_\_\_\_

☐ High Blood Pressure

☐ Cancer

☐ Herpes

Describe, if needed: \_\_\_\_\_

3.

Please indicate any surgery or hospitalization that you have had and the date:

4.

Please describe any health problems or symptoms that you are having at this time:

5. ☐ Yes ☐ No

Do you or any family member have a history of problems with anesthesia?

If yes, please describe: \_\_\_\_\_

6. ☐ Yes ☐ No

Do you have any objections to any form of medical treatment (eg, blood transfusion)?

If yes, please describe: \_\_\_\_\_

W. Counts, MD \* W. Cruz, MD \* K. Eaton, MD \* A. van Haastert, MD \* J. Goldberger, MD

**Exposures Affecting Health**

1. ☐ Yes ☐ No **Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped?**  
If yes, how many packs per day? \_\_\_\_\_ If former smoker/user, when did you quit? \_\_\_\_\_
2. ☐ Yes ☐ No **Do you drink alcoholic beverages now or did you before you became pregnant?**  
If yes, please indicate number of drinks per week: \_\_\_\_\_  
What type of drinks? \_\_\_\_\_
3. **Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines:** \_\_\_\_\_  
\_\_\_\_\_
4. ☐ Yes ☐ No **Have you used any street drugs since your last menstrual period (eg, cocaine, marijuana, opioids)?**  
If yes, please indicate number of uses per week: \_\_\_\_\_  
What type of drugs? \_\_\_\_\_
5. ☐ Yes ☐ No **Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs?**
6. ☐ Yes ☐ No **Have you been exposed to chemicals (eg, pesticides, lead, hazardous material/agents) or radiation (eg, X-rays) since you became pregnant? If yes, please describe:** \_\_\_\_\_
7. ☐ Yes ☐ No **Are you on a restricted diet?**  
If yes, please describe: \_\_\_\_\_

**Gynecologic Health History**

1. **When was your last Pap test?** \_\_\_\_\_  
☐ Yes ☐ No **Have you received all three doses of the HPV vaccine?**  
☐ Yes ☐ No **Have you ever had an abnormal pap test?**  
If yes, when and how were you treated? \_\_\_\_\_  
\_\_\_\_\_  
What was the diagnosis? \_\_\_\_\_  
☐ Yes ☐ No **Have you ever had HPV?**
2. ☐ Yes ☐ No **Have you ever had** ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease  
If yes, when, how, and where were you treated? \_\_\_\_\_
3. ☐ Yes ☐ No **Have you ever had herpes?**  
If yes, where do you have outbreaks? \_\_\_\_\_  
If yes, how often do you have outbreaks? \_\_\_\_\_  
☐ Yes ☐ No **Have you ever had syphilis?**  
If yes, how, when, and where were you treated? \_\_\_\_\_
4. ☐ Yes ☐ No **Have you ever used an intrauterine device (IUD) for contraception?**  
If yes, please indicate when: \_\_\_\_\_  
☐ Yes ☐ No **Did you have any problem with the IUD?**  
If yes, please describe: \_\_\_\_\_
5. ☐ Yes ☐ No **Have you been treated for infertility?**  
If yes, please describe when and treatment received: \_\_\_\_\_  
\_\_\_\_\_
6. ☐ Yes ☐ No **Do you have any other concerns related to your past health history? If yes, please list:** \_\_\_\_\_  
\_\_\_\_\_

W. Counts, MD \* W. Cruz, MD \* K. Eaton, MD \* A. van Haastert, MD \* J. Goldberger, MD

## Family History &amp; Genetic Screening

|                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.                                             | What is your ethnicity? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What is the ethnicity of the baby's father? _____                                                                                                                                                                                                                                                                                                                           |
| 2.                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Have you or has the baby's father had a child born with a birth defect?<br>If yes, please describe: _____                                                                                                                                                                                                                                                                   |
| 3.                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Did either you or the baby's father have a birth defect?<br>If yes, please describe: _____                                                                                                                                                                                                                                                                                  |
| 4.                                             | Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):<br><br><div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                             |
| How is this child/person related to you? _____ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                             |
| 5.                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?<br>If yes, have either of you had genetic counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, have either of you had chromosomal testing? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Where and what were the results? _____ |
| 6.                                             | Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No Eastern European Jewish (Ashkenazi) Ancestry<br>If yes, have you had tay-sachs screening tests? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, have you had a canavan screening test? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, have you had familial dysautonomia screening? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date: ____/____/____ Result: _____<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No African American<br>If yes, have you had sickle cell screening? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date: ____/____/____ Result: _____<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No Mediterranean Ancestry or Southeast Asian Ancestry<br>If yes, have you had screening for inherited forms of anemia such as Thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No French Canadian or Cajun Ancestry<br>If yes, have you had Tay-Sachs screening tests? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                             |
| 7.                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Have you had cystic fibrosis screening?                                                                                                                                                                                                                                                                                                                                     |
| 8.                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Have you had any other genetic carrier screening, such as an expanded carrier screening?<br>Screening: _____ Date: ____/____/____ Result: _____                                                                                                                                                                                                                             |
| 9.                                             | Please list any other concerns you have about birth defects or inherited disorders:<br><br><div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                             |
| 10.                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Do you want a test that will tell you about your risk to have a baby with Down syndrome?                                                                                                                                                                                                                                                                                    |
| 11.                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Is the father 45 years or older?                                                                                                                                                                                                                                                                                                                                            |

**W. Counts, MD \* W. Cruz, MD \* K. Eaton, MD \* A. van Haastert, MD \* J. Goldberger, MD**

| Psychosocial Screening*                                                                                                           |                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments?                                                                                                                           |
| 2. <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | Do you feel unsafe where you live?                                                                                                                                                                                                        |
| 3. <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | Are you exposed to second-hand smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), and vaped? |
| 4. <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?                                                                                                                                             |
| 5. <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?                                                                                                                                                   |
| 6. <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | Has anyone forced you to perform any sexual act that you did not want to do?                                                                                                                                                              |
| 7. On a 1–5 scale, how do you rate your current stress level? <b>Low</b> <b>1</b> <b>2</b> <b>3</b> <b>4</b> <b>5</b> <b>High</b> |                                                                                                                                                                                                                                           |
| 8. How many times have you moved in the past 12 months?                                                                           | _____                                                                                                                                                                                                                                     |
| 9. If you could change the timing of this pregnancy, would you want it                                                            | <input type="checkbox"/> earlier <input type="checkbox"/> later <input type="checkbox"/> not at all / NA                                                                                                                                  |

\*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

**PATIENT SIGNATURE**

**PRINT NAME**

**DATE**[illegible]

**OBSTETRIC MEDICAL HISTORY (FORM D, page 4 of 4)**

Tricefy™ your ultrasound at



- ☐ I want my ultrasound images delivered digitally as an email or text.

Email Address: \_\_\_\_\_

Mobile Phone Number: (\_\_\_\_\_)\_\_\_\_\_

- ☐ I authorize the sending of images during my pregnancy.
- ☐ I have read, understand, and agree to this disclaimer.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Disclaimer and Authorization

Tricefy™ is a communication service licensed to your provider. This Disclaimer and Authorization Agreement sets forth the terms and conditions under which you, the undersigned patient authorize Your Provider to transmit your ultrasound examination through Trice Imaging, Inc. to a mobile phone number and email address of your choice. This Agreement will become effective on the date of your signature and will terminate after all images throughout your current pregnancy are sent to you.

After you complete and sign this Agreement, a mobile telephone number or email address you designate will be entered into our ultrasound system and re-verified with you. When your ultrasound screening is complete, in accordance with your provider's policies and procedures, the sonographer will trigger the ultrasound machine to send an encrypted copy of your examination to the Tricefy™ server. The server will reformat and encrypt the file and provide access to the examination through your mobile phone number and a text or email. The physician will have the discretion to determine whether your ultrasound screening is complete and whether to transmit your images to Tricefy™. The Physician has the right to refuse to transmit or to delay the transmission of your images. Both the text and email message will contain secure links and instructions on how to access the images. Images and videos can be accessed and downloaded to your mobile phone and computer.

You agree to pay all costs for the services if applicable. Transmission of the images through Trice Imaging, Inc. is not a medical service. The transmitted images are not considered diagnostic medical images and are not a part of your medical record; they are not to be used for your health care, diagnosis or treatment. If you want to see your medical records, you need to contact your provider, who is responsible for maintaining your medical records. Neither your provider, nor Trice Imaging, Inc. is responsible for the security of the transmitted images once the text and email recipients you have designated download the images. By directing your provider to transmit the images to an email address and telephone number that you specify, you authorize your provider and Trice Imaging, Inc. to provide the images to the person who owns or uses the email address and telephone number and any persons who may have access to the telephone number and email address. We would recommend immediate download of any images, as the link to the images will only be active for a maximum of 90 days. Any transmission of additional images will be considered new services, the cost for which the patient is obligated to pay, if applicable. Trice Imaging, Inc. will not store the images on its server for you.

As a licensee of Tricefy™ through Trice Imaging, Inc., your provider is permitted to offer the services under the terms and conditions of the license. This is the sole agreement between Trice Imaging, Inc. and your provider.

