A-Z Women's Center

Health History

.

Our staff is here to help you with answers to any questions or concerns that you may have. Your complete understanding is essential to your consent, which must be obtained before the procedure. We will do our best to address all of your needs and concerns. Please answer as completely as possible; all information is strictly confidential.

Name ____ **Date of Birth** ______________________ **Age** ________

Address ____City_______________State________________Zip___________

Phone Number__________________________ Education ______________________ Race_______________ Hispanic YES NO

Emergency contact________________________________ Relationship to you________________________________

Phone # where they can be reached if necessary (**WE WILL ONLY CALL IN CASE OF AN EMERGENCY**) __________________________

Have you been a patient here before? __________

Menstrual History

Are your periods regular? Yes No If no, please explain____

Bleeding is usually **LIGHT** **MEDIUM** **HEAVY** How many days of flow? _________

Cramping is usually **MILD** **MODERATE** **SEVERE**

Other symptoms with period____

First day of last period__________________________ Any bleeding or cramping since your last period: Yes No

Pregnancy History

Total number of pregnancies including this one__________ Number of vaginal births______ Number of C-sections_________

Number of miscarriages______ Number of abortions______ Tubal/Ectopic pregnancies______

Any bleeding problems with previous pregnancies______________________

Symptoms during this pregnancy: Nausea/Vomiting ( ) Breasts tender ( ) Fatigue ( ) Unusual Vaginal Discharge ( )

Bleeding/Spotting ( ) Cramping/Pain ( ) Other ______________________________

Allergies____

____

Medications Presently Taking____

____

Are you currently Breastfeeding? Yes No

Habits

Alcohol:	Never ( )	1-2 drinks/week ( )	3-5 drinks/week ( )	5+ drinks/week ( )
Tobacco:	Never ( )	Past use/Quit ( )	Current ( ) How much________________________	
Other drugs:	Never ( )	Past use/Quit ( )	Current ( ) What____________________________	

Previous Surgeries____

____

Past Medical History (circle all that apply to you only)

Cardiovascular Migraines Rheumatic Fever Heart Murmur Heart problems Phlebitis (vein clots) High Blood Pressure Stroke Dizzy/fainting spells Anemia (low blood count) Bleeding problems Other__________________

Pulmonary Asthma Bronchitis Tuberculosis Emphysema Other_______________________________________

Metabolic Diabetes Thyroid Other_______________________________________

Renal Kidney problems/infections Bladder problems/infections Other___________________________________

Other Hepatitis/Jaundice Skeletal/back problems Cancer Immune-Deficiencies Other_____________________

A-Z Women's Center

Health History

Gynecologic Infertility Abnormal Pap Smear Endometriosis Fibroids Painful Intercourse Cancer Pelvic pain
Herpes (genital sores) Tubal infections/PID Sexually Transmitted Infections Recurrent vaginal infections
Other___________________________________

Mental Health Anxiety Depression Physical/Mental Abuse Chemical Dependency Other______________________________

Would you like information on contraception at your visit? Yes No

If Yes, which one(s) are you interested in:
Oral Pills Depo-Provera (The Shot) The Patch The Ring IUD Diaphragm Condoms Foam/Film
Sponge Spermicide Rhythm Tubal Sterilization Implant

Family History Diabetes Cancer High Blood Pressure Heart Disease Stroke Other____

Please check any concerns that you have:
( ) Understanding the surgical procedure
( ) Uncertain of decision
( ) Is this truly confidential
( ) Is this going to hurt
( ) Is this painful for the fetus
( ) Possible complications during and after
( ) Possible effect on future pregnancies
( ) Possible effects on future ability to have a baby
( ) Have had a bad experience before
( ) Other concerns (please explain)____
____

Is this pregnancy a result of consensual intercourse? Yes No
Does the person involved know about your decision? Yes No Are they supportive? (If applicable)_______________
Is anyone forcing you to terminate this pregnancy Yes No
Do you have emotional support? Yes No

Who referred you here today, or how did you hear about us?
Internet Yellow Pages Friend/Family Returning Patient Other _________________________________

Doctor (name) ____

Clinic/Hospital ____

I GIVE THE INFORMATION REQUESTED ON THIS PAGE FREELY. IT IS COMPLETE AND FACTUAL TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS FOR A-Z WOMEN'S CENTER USE ONLY AND WILL NOT BE RELEASED TO ANYONE ELSE WITHOUT MY WRITTEN PERMISSION EXCEPT BY COURT ORDER. I AUTHORIZE A-Z WOMEN'S CENTER CARE PHYSICANS AND STAFF TO PERFORM RESONABLE AND NECESSARY MEDICAL EXAMINATION, TESTING, AND TREATMENT FOR THE CONDITION WHICH HAS BROUGHT ME TO A-Z WOMEN'S CENTER.

Patient Signature____ **Date**____

Staff Signature____ **Date**____

A-Z Women's Center

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A-Z Women's Center is committed to protecting the privacy of your health record and the confidentiality of your visit. Your health care record, known as a chart, and the information it contains, will not be disclosed to anyone or any agency outside of *A-Z Women's Center* without written authorization from you, unless such a release is required by law.

A-Z Women's Center will use your health information for the purpose of:

- ◊ **Treatment** - For example, information obtained will be recorded in your record and used to determine the best course of treatment for you. This may include the need for us to contact you to provide information about treatment or other health-related issues.
- ◊ **Regular Healthcare Operations** - For example, members of the medical staff may use information in your health record to assess the care you received and outcomes of your care. This information will then be used in our continuous quality improvement program.

Disclosures required by law

- ◊ **Food and Drug Administration (FDA)** - As required by law, A-Z Women's Center may disclose to the FDA health information relative to adverse events with respect to product defects, products recalls, repairs or replacement.
- ◊ **Public Health** - A-Z Women's Center may disclose your health information, as required by law, to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- ◊ **Law Enforcement** - A-Z Women's Center may disclose health information for law enforcement purposes as required by law or in response to valid subpoena.

Your Health Information Rights:

Although your health record is the physical property of A-Z Women's Center**,** the information it contains belongs to you. You have the right to:

- ◊ Request a restriction on certain uses and disclosures of your information
- ◊ Obtain a paper copy of the notice of information practices upon request
- ◊ Inspect a copy of your health record
- ◊ Amend your health record as provided in NEV. REV. STAT. § 629.051
- ◊ Obtain an accounting of disclosures of your health information
- ◊ Request communication of your health information by alternative means or at alternative locations
- ◊ Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities:

A-Z Women's Center is required to:

- ◊ Maintain the privacy of your health information
- ◊ Provide you with notice as to A-Z Women's Center legal duties and privacy practices with respect to information A-Z Women's
- ◊ Center collects and maintains about you
- ◊ Abide by the terms of this notice
- ◊ Notify you if we are unable to agree to a requested restriction
- ◊ Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

Nevada State law requires that medical records be kept for at least 5 years. It is the goal of A-Z Women's Center to maintain records for 7 years. Medical records of patients who are younger than 23 will be retained until that patient is 23 and 5 years after that date. After those 5 years, the medical records will be destroyed.

A-Z Women's Center reserves the right to change practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will make a reasonable effort to notify you of this change.

For More Information or to Report a Problem:

If you have questions, or if you want to report a problem, please contact Bridget, ***A-Z Women's Center*** Privacy Officer, at (702) 892-0660. Complaints may also be filed with the Secretary of Health and Human Services, an act for which no retaliation will occur.

I have read this privacy notice and I have been given ample time to ask questions regarding the information it contains. I understand that A-Z Women's Center will hold my record to the highest standard of privacy and confidentiality and will only release my personal health information when so authorized by me in writing, or when required by law to do so.

______________________________	______________________________	____________________
Patient Name	Patient Signature	Date
______________________________	______________________________	____________________
Staff Name	Staff Signature	Date

Healthcare Providers: *Counsel the patient on the risks of Mifeprex*. Both you and the patient must sign this form.*

Patient Agreement:

1. I have decided to take Mifeprex and misoprostol to end my pregnancy and will follow my provider's advice about when to take each drug and what to do in an emergency.

2. I understand:
  a. I will take Mifeprex on Day 1.
  b. My provider will either give me or prescribe for me the misoprostol tablets which I will take 24 to 48 hours after I take Mifeprex.

3. My healthcare provider has talked with me about the risks including:
- heavy bleeding
- infection
- ectopic pregnancy (a pregnancy outside the womb)

4. I will contact the clinic/office right away if in the days after treatment I have:
- a fever of 100.4°F or higher that lasts for more than four hours
- severe stomach area (abdominal) pain
- heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
- stomach pain or discomfort, or I am "feeling sick", including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol

5. My healthcare provider has told me that these symptoms could require emergency care. If I cannot reach the clinic or office right away my healthcare provider has told me who to call and what to do.

6. I should follow up with my healthcare provider about 7 to 14 days after I take Mifeprex to be sure that my pregnancy has ended and that I am well.

7. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with Mifeprex and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.

8. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.

9. I have the MEDICATION GUIDE for Mifeprex. I will take it with me if I visit an emergency room or a healthcare provider who did not give me Mifeprex so that they will understand that I am having a medical abortion with Mifeprex.

10. My healthcare provider has answered all my questions.

Patient Signature: ______________________ **Patient Name (print):** ______________________ **Date:** __________

The patient signed the PATIENT AGREEMENT in my presence after I counseled her and answered all her questions. I have given her the MEDICATION GUIDE for Mifeprex.

Provider's Signature: ______________________ **Name of Provider (print):** ______________________ **Date:** __________

After the patient and the provider sign this PATIENT AGREEMENT, give 1 copy to the patient before she leaves the office and put 1 copy in her medical record.

03/2016

*MIFEPREX is a registered trademark of Danco Laboratories, LLC. DANCO