A-Z Women's Center

Health History

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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 <u>you</u> 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_____

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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

11/1/19

A-Z Women's Center
1670 E. Flamingo Rd. Suite C, Las Vegas, NV 89119
p: (702) 892-0660 f: (702) 650-0549

INFORMED CONSENT FOR ABORTION TREATMENT, ANESTHETIC ADMINISTRATION AND/OR OTHER MEDICAL SERVICES DEEMED NECESSARY

.

DATE _____

NAME _____ DOB _____ AGE _____

ADDRESS_____ CITY _____ STATE _____

Phone (home) _____ Phone (cell) _____

Please list 2 persons that may be contacted in case of emergency: (required)

Name	Address	Phone	Relationship	Are they aware you are here?
Name	Address	Phone	Relationship	Are they aware you are here?

I, _____ request and consent to the performance upon me of a pregnancy termination procedure by Dilation and Curettage (D&C) or Dilation and Evacuation (D&E). I affirm this to be my personal choice with the understanding that I have the alternative to continue the pregnancy. No one is coercing or forcing me to make this decision or sign this form.

I also consent to the insertion of osmotic dilators and intra-uterine medications, if necessary, to facilitate the procedure.

I understand that the pregnancy/products of conception will be removed during the procedure, and I consent to its examination by the physician, assistants, or pathologist. I consent to its disposal by the clinic in a manner deemed appropriate.

I further consent to the performance of reasonable indicated tests and procedures, to include, but not to be limited to, ultrasound examination, urine and blood tests. If dilators are inserted, I understand that the abortion has been started and pregnancy may have been interrupted and I must return for completion of the abortion procedure as instructed.

I have completely and truthfully disclosed my medical history including allergies, prescribed and non-prescribed medications and any history of adverse reactions to local anesthetics, medicines, or drugs. I consent to the physician relying on this disclosure as complete.

I consent to the administration of anesthesia and/or medications for pain and anxiety, if I so choose. I understand that anesthetics and/or pain medications do not always eliminate all pain and cramping. I understand that in a small number of cases, severe reactions, including shock and death, have occurred. No guarantees to the contrary have been made to me.

INITIALS _____ I choose **Nitrous Oxide Gas**: This consists of Nitrous Oxide Gas (laughing gas) to breathe during the procedure. You may drive yourself home and participate in normal activities as this has no effect on your ability to do so.

INITIALS _____ I choose **Intravenous Anxiety and Pain Relief**: This consist of medications given intravenously to relieve anxiety and pain. This is NOT General Anesthesia or Deep Sedation. You may feel sleepy during the procedure and may be drowsy for several hours after you leave our office. We strongly recommend that you do not drive, operate machinery or make any important decisions for about 24 hours.

I understand that the complications associated with pregnancy termination are generally much less severe and less frequent than with childbirth. Nonetheless, I realize, as is true with childbirth or any kind of surgery, that there are inherent risks of minor and major complications that may occur, even without the fault of the physician. These risks include, but are not limited to severe loss of blood, infection, injury to the uterus and/or surrounding structures, cardiac arrest, stroke and embolism. Other risks and possible complications specific to the abortion procedure are as follows: (in approximately decreasing order of frequency)

Post abortion syndrome: In a few cases the uterus bleeds and forms clots that are retained inside. As the uterus reacts to the clots by cramping to expel the clots, this results in increasingly severe cramping and pain. To relieve the pain, and empty the uterus, a repeat suction procedure may be required (unless the uterus successfully expels the clots). This usually occurs within a few hours after the abortion.

Infection: Caused by the inevitable presence of bacteria in the vagina gaining access to the uterus is reported in a small percentage of cases. You will be given an antibiotic to take to decrease the chance of infection. Most infections respond to outpatient antibiotics, but occasionally hospitalization is necessary. ⇒

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Bleeding: In a few cases there is more bleeding than expected. This may require an immediate repeat of the procedure or hospitalization for observation and treatment. If this excessive bleeding occurs after the abortion, hospitalization and possible transfusion of blood and dilation and curettage (D&C) may have to be performed.

Laceration: Occasionally the cervical opening and/or cervical canal may be torn. In some cases, only a few stitches are necessary to repair the tear. However, this complication can cause severe bleeding and require hospitalization.

Perforation: Rarely, an instrument used in the procedure may go through the wall of the uterus. Should this occur, hospitalization might be necessary for observation, completion of the procedure, and/or repair or removal of the uterus or any damaged surrounding organs.

Failure to Terminate Pregnancy: In a very small percentage of early pregnancies, the abortion procedure fails to end the pregnancy and results in an incomplete abortion. If this should occur, another abortion procedure, usually a repeat vacuum aspiration would be recommended because the first attempt may have prevented normal development of the pregnancy.

Hysterectomy: This is removal of the uterus. As a result of pre-existing conditions or some of the above complications (including perforation, bleeding, infection), a hysterectomy may be necessary, but is very rare.

Tubal Pregnancy: This is not a risk or complication of the abortion procedure, but approximately 1 in every 100 pregnancies is located outside of the uterus. If this condition goes undiagnosed and untreated, it may lead to rupture of the tube which carries a high mortality. This would require hospital admission and could not be done by the abortion procedure.

I understand that the physician, counselor, or assistants will answer any questions that I have, and that I will ask all questions before leaving the office. If I have questions or complications after leaving, I agree to call the clinic immediately. I agree to follow-up with the clinic in the event of complications

I understand that I may be treated for any resulting complications at *A-Z Women's Center* at no additional charge to me. However, if hospitalization is required, or if I should go to another physician or healthcare facility then I will be responsible for all charges.

I certify that I have read, had explained to me, and fully understand the informed consent that I am signing, and I agree, in light of that consent, to the pregnancy termination procedure that I have requested. I understand that I may have a copy of this consent form at my request.

If requested or necessary, I authorize you to send a copy of my medical records or other information to the referring health care provider, my insurance carrier, or to Hospital or Emergency Room personnel. Additionally, I authorize *A-Z Women's Center* to obtain records from other caregivers regarding the services performed here.

Patient Signature_____ **Date**_____ **Time**_____

Staff Signature_____ **Date**_____ **Time**_____

If needed, I have explained the consent, instructions, and the procedure to this patient. She understands the materials and consents under the above conditions.

Interpreter Relation Date/Time