PATIENT HISTORY Name: Date of Birth:

Personal Histo of Past Illness

Major Illness	Yes (Date)	Ma-or Illness	Yes (Date)
		Glaucoma	
Arthritis/Joint ain		Headaches chronic onl	
Asthnna		Heart Disease	
Back roblems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clots in lun s or le s		Hi h Blood Pressure	
Blood Transfusions		Hi h Cholesterol	
Bowel Problems		HIV/Aids	
Broken bones		Kidne Infections/Kidne Stones	
Cancer		Pneumonia/Lun Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcers	
Chicken ox		Rheumatic Fever	
Collagen Vascular Disease us Lu		Seizures/Convulsions/E ile s	
De ression or Anxiet circle		Sexuall Transmitted Disease	
Diabetes		Stroke	
Eatin Disorders		Th roid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN Histo

Problem	Yes	No	Problem	Yes	No
Abnormal hair rowth			Infertilit		
Abnormal Bleeding			Ovarian C st		
Abnormal Pa Smear			Osteo orosis		
Breast Problems			Sexual Problems		
Cyst of Vulva			Sexuall transmitted disease		
DES Exposure			Uterine Abnormalit		
Endometriosis			Urinar Leaka e		
Fibroicl Uterus			Va inal/Vulvar Infection		

Sur eries

Surc er	Yes	No	Date/Comments
Abdominal Surger			
C-Section Delivery			
Dilation & Curettage D & C			
Hysterectomy			
Hysteroscopy out patient			
Laparoscopy out patient			
Vaginal Surgery			
Bartholin Glands Surger			
Other Please List :			

Social Histo

Preferred Name:	PCP:	Occu ation:

Number of people in household: Sin le Married Widowed Divorced Separated Living w/ partner

Education last grade com leted . Name of si nificant other:

Children's Names:

Seat Belt Use: Always Frequently Occasionally Never

Occupational Risks: None Biohazard Chemical Ph sical Labor

How many da s per week do ou exercise? How many acks of cigarettes per day do you smoke?

How many times per week do ou drink alcohol?

Do you use any of the following? cocaine narcotics marihuana hallucinogens

Famil Histo Please check those that a l

Illness	Mother	Father	Siblin	Child	Maternal Grandparent	Paternal Grandparent	Other
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Alzheimer's Disease							
Birth Defects							
Blood Clots in lun s or legs							
Diabetes							
Drinkin or Dru roblems							
Endometriosis							
Fibroids							
Heart Disease							
He atitis							
High Blood Pressure							
Hi h Cholesterol							
HIV/AIDS							
Mental Illness/De ression							
Osteo orosis							
Stroke							
Tuberculosis							
Other							

Obstetric Histo

#Total Pregnancies		#Full Term		#Premature		#Elective Abortion	
# Miscarria e		#Ecto ic		#Multi les		#Living	

Pregnancy #	1	2	3	4	5	6
Pregnancy Outcome F=Full term, P=Premature, M=Miscarriage						
Deliver Date						
Weeks at Deliver						
Length of labor hrs.						
Epidural/Anesthesia						
Delivery Type V=Vaginal, C=C-section						
Did ou have Pre-term Labor?						
Delivery Location						
Who delivered our bab ?						
Bab weight?						

Baby Sex?						
Bab Name?						
Com lications	Please check an that a					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Post partum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complications						

pos Reorder 1207294

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

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

PATIENT NAME: ________________________ DATE OF BIRTH: ________________

ADDRESS:

______________ ______________ ________ ________
and Street City State Zip

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

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

Name: ________________________ Relationship: ________________

Name: ________________________ Relationship: ________________

Name: ________________________ Relationship: ________________

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

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

_____

The practice may disclose my personal health information to the individual(s) above in discussions in

_____ my presence and when I am not physically present, including disclosures bv telephone, fax, email or regular mail.

Other conditions of disclosure:

_____ ____

I DO NOT wish to allow access to my information to anyone (other than as stated above for further

_____ treatment or payment purposes to other physicians or my insurance company.)

Patient signature: ____ Date: ______________

Witness: ____ Position: ____________

Printed name of witness: ______________________________

ATHENS OBSTETRICS & GYNECOLOGY, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF

PRIVACY PRACTICES

Patient Name ____ Account # ________________

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

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

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

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

____

Signature of Patient or Personal Rep

Date

Print Name of Patient or Personal Rep

Personal Representatives Authority