

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I acknowledge that I have received The Center for Women's Rights and Responsibilities policy and have been offered a copy of the entire HIPAA privacy notice. This notice is also available at all times in The Center for Women's waiting room and I may request an additional copy of it at any time by contacting the Office Manager at 330-702-1281.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to mail to my home address |
| <input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> OK to mail to my work address |
| <input type="checkbox"/> Work Telephone | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> OK to leave message with detailed information | |
| <input type="checkbox"/> Leave message with call back number only | |

YOU MAY DISCUSS MY HEALTH INFORMATION WITH:

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature

Date

Printed Name

Date of Birth

THE CENTER OF WOMEN

PATIENT ADVOCACY PROGRAM

The doctor and patient are desirous of entering into and/or maintaining a positive physician/patient relationship that focuses on quality patient care and open lines of communication. The parties to this agreement shall agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the physician/patient relationship, the patient agrees to submit in writing to the MaternOhio Mediation Program, any dispute, controversy or disagreement arising out of or relating to the physician/patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to the MaternOhio Mediation Program, the parties shall use negotiation in an attempt to reach a voluntary resolution of their differences.
2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter shall be submitted to mediation in accordance with the MaternOhio Mediation Program Rules of Procedure.

Mediation is a process in which a neutral third party helps the doctor and the patient discuss the issues that have arisen between them with the ultimate goal of resolving any problems. Either party is entitled to seek legal representation at any time, but MaternOhio wishes to provide the patient with the opportunity to settle any problems that may have arisen without the need to incur additional costs and fees.

These Mediation Rules of Procedure provide in part that:

- The patient is not required to reach a resolution in mediation.
- The mediator (or comediators) will be a neutral third party who is trained in mediation.
- All mediation sessions are considered confidential as defined in Ohio Revised Code 2317.023.
- MaternOhio will pay the costs of the mediation.
- The date, time and place of any mediation session shall be scheduled by the mediator in consultation with the parties.
- The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
- Any agreements reached by the parties shall be in writing and signed by both parties.
- Parties considering negotiation or mediation should remember that any decisions may affect their legal rights. Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

It is the goal of MaternOhio Management, Inc. that all physicians and patients engage in a cooperative approach to ensure quality healthcare and that any conflicts that may arise between them will be resolved in the same cooperative style through mediation.

Patient Signature

Date

Witness

Date

NEW PATIENT FORM

PATIENT NAME: _____ DOB: _____ AGE: _____ DATE: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

REASON FOR VISIT: _____

PAST MEDICAL HISTORY: Check if YOU have ever had or been diagnosed with any of the following.

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Fibroids	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Other STDs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pelvic Pain
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Polycystic Ovaries
<input type="checkbox"/> Breast Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pulmonary Embolus
<input type="checkbox"/> Cancer - Type?	<input type="checkbox"/> Herpes	<input type="checkbox"/> Reflux
<input type="checkbox"/> Cervical Dysplasia	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Deep Venous Thrombosis	<input type="checkbox"/> HPV	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Depression	<input type="checkbox"/> Infertility	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Trichomonas
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Other	

HEALTH MAINTENANCE

Last Colonoscopy	Year	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Last Mammogram	Year	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Previous Abnormal Mammograms	<input type="checkbox"/> No	<input type="checkbox"/> Yes - When?	<input type="checkbox"/> Where?
Last Pap Smear	Year	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Previous Abnormal Pap Smears	<input type="checkbox"/> No	<input type="checkbox"/> Yes - When?	<input type="checkbox"/> Treatment?
Last Bone Density Test	Year	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

SURGICAL HISTORY: Please check any that you have had and list date.

	Date	Date	Date
<input type="checkbox"/> Appendix		<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Laparoscopy
<input type="checkbox"/> Breast		<input type="checkbox"/> Ovaries Removed	<input type="checkbox"/> Ovary
<input type="checkbox"/> Heart		<input type="checkbox"/> Left	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Cervix		<input type="checkbox"/> Right	<input type="checkbox"/> Tubal Reversal
<input type="checkbox"/> Gallbladder		<input type="checkbox"/> Both	<input type="checkbox"/> Vaginal Repair
<input type="checkbox"/> D&C	Reason		<input type="checkbox"/> Tonsils
<input type="checkbox"/> Cesarean Section	Type:		<input type="checkbox"/> Other
	<input type="checkbox"/> Abdominal		
	<input type="checkbox"/> Vaginal		
	<input type="checkbox"/> Laparoscopic		

GYNECOLOGICAL HISTORY: Fill in all blanks and check all that are appropriate.

Last menstrual period: _____ Not Applicable due to: Menopause Mirena IUD
 Hysterectomy Breastfeeding
 Ablation Other

Flow: Light Medium Heavy
 Clots: Yes No
 Severe Cramps: Yes No
 # of days you bleed: _____
 # of days between periods: _____ (i.e. 28,30)

Breakthrough bleeding: Yes No
 Bleeding after Intercourse: Yes No
 Current Sexual Partner: Male Female

Age of first menstrual cycle: _____ Age of first intercourse: _____

Number of **NEW** sexual partners since last visit: _____ Lifetime number of sexual partners: _____

Are you currently sexually active? Yes No

Type of contraception currently used: Pills NuvaRing DepoProvera
 Condoms Tubal Ligation Vasectomy
 IUD Diaphragm Foam
 Other _____

Do you want STD testing? Yes No

OBSTETRICAL HISTORY:

of Pregnancies: _____ Full Term: _____ Abortions: _____ Miscarriages: _____ Living: _____ Multiple: _____

DATE	WEEKS PREGNANT	HOURS LABOR	SEX	WEIGHT	VAGINAL OR C-SECTION	COMPLICATIONS/DETAILS	WHERE

SOCIAL HISTORY: Fill in all blanks and check all that are appropriate.

Alcohol Use: Never Current Former Amount _____

Recreational Drug Use: Never Current Former Amount _____

Tobacco Use: Never Current Former Amount _____

Domestic Violence: Emotional: Current Past
 Physical: Current Past
 Sexual: Current Past

Do you have a living will? Yes No

CURRENT MEDICATIONS: Please list all medications - even over-the-counter, vitamins, herbals, etc. with dosages and who prescribed

MEDICATION NAME	DOSAGE	PRESCRIBING DOCTOR

ALLERGIES TO MEDICATIONS: Please list your reaction to the medications (Write "None" if no known drug allergies)

FAMILY HISTORY Please check if any of your family members have had the following & list who had it.

Relation	Relation	Relation
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pulmonary Embolus
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> DVT	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Birth Defects
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Other

REVIEW OF SYSTEMS Please check if you are **CURRENTLY** experiencing any of these symptoms.

CONSTITUTIONAL	GASTROINTESTINAL	INTEGUMENTARY
<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Rash
<input type="checkbox"/> Unexplained Weight Gain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Skin Lesions
<input type="checkbox"/> Fever	<input type="checkbox"/> Vomiting	NEUROLOGIC
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Seizures
<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Bloating	<input type="checkbox"/> Dizziness
HEENT	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Syncope (Fainting / Passing out)
<input type="checkbox"/> Headaches	<input type="checkbox"/> Constipation	ENDOCRINE
<input type="checkbox"/> Problems with teeth/gums	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Cold Intolerance
BREAST	GENITOURINARY	<input type="checkbox"/> Heat Intolerance
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Pain with Intercourse	<input type="checkbox"/> Excessive Hair Growth
<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Spotting with or after Intercourse	
<input type="checkbox"/> Breast Discharge	<input type="checkbox"/> Abnormal Vaginal Discharge	
<input type="checkbox"/> Changes in Skin	<input type="checkbox"/> Vaginal Dryness	
CARDIOVASCULAR	<input type="checkbox"/> Urinary Frequency	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Urinary Urgency	
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Urinary Retention	
RESPIRATORY	<input type="checkbox"/> Painful Urination	
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in Urine	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Incontinence	
<input type="checkbox"/> Cough		

Patient's Signature _____

Doctor's Signature _____