A WOMAN'S PLACE,
A MEDICAL CORPORATION
TATIANA FROMLAK, M.D., INC. F.A.C.O.G.
BOARD CERTIFIED, OBSTETRICS & GYNECOLOGY
729 SUNRISE AVE, STE 800 ROSEVILLE, CA 95661

Health History Questionnaire

DATE OF BIRTH: _____

LAST NAME_____FRIST NAME _____MI:_____

ALLERGIES TO MEDICATIONS: _____

ALLERGIES TO LATEX YES ☐ NO ☐

MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐

Gynecological History:

AGE OF FIRST PERIOD _____ **DATE OF LAST PERIOD**_____

REGULAR/IRREGULAR PERIODS? IF IRREGULAR, HOW OFTEN? _____HOW MANY DAYS OF FLOW _____

ARE YOUR MENSTRUAL CRAMPS: MILD ☐ MODERATE ☐ SEVERE☐ ?

ANY BLEEDING BETWEEN PERIODS **YES** ☐ **NO** ☐

ANY BLEEDING AFTER MENOPAUSE **YES** ☐ **NO** ☐

DATE OF LAST PAPSMEAR_____

HAVE YOU HAD ANY ABNORMAL PAPSMEARS **YES** ☐ **NO** ☐ **IF YES, WHEN?** _____

ANY PROCEDURES DONE FOR TREATMENT: NONE☐ COLPOSCOPY ☐ LEEP ☐ CRYO☐ COLD KNIFE CONE☐ OTHER☐ _____

HAVE YOU HAD THE VACCINATION FOR HPV **YES** ☐ **NO** ☐

HAVE YOU EVER HAD INTERCOURSE **YES** ☐ **NO** ☐

DO YOU HAVE PAIN WITH INTERCOURSE **YES** ☐ **NO** ☐

BIRTH CONTROL METHOD: BIRTH CONTROL PILLS ☐ IUD ☐ NEXPLANON ☐ DIAPHRAGM ☐

FOAM & CONDOMS ☐ TUBAL LIGATION ☐ VASECTOMY ☐ OTHER ☐ _____

HAVE YOU HAD A VAGINAL INFECTION? YEAST ☐ TRICHOMONAS ☐ BACTERIAL ☐

ARE YOU HAVING TROUBLE WITH VAGINAL DISCHARGE? **YES** ☐ **NO** ☐ **IF YES, DESCRIBE** _____

HAVE YOU HAD A VENEREAL DISEASE? GONORRHEA ☐ CHLAMYDIA ☐ HERPES ☐ WARTS☐ SYPHILIS ☐

HAVE YOU HAD A PELVIC INFECTION **YES** ☐ **NO** ☐

HOW MANY PREGNANCIES? _____HOW MANY CHILDREN? _____ NUMBER OF MISCARRIAGES OR ABORTIONS? _____

HEALTH MAINTENANCE

HAVE YOU HAD A MAMMOGRAM YES ☐ **NO** ☐ **IF YES, WHEN**_____

HAVE YOU HAD A COLONOSCOPY **YES** ☐ **NO** ☐ **IF YES, WHEN** _____

HAVE YOU HAD A BONE DENSITY TEST (DEXA) **YES** ☐ **NO** ☐ **IF YES, WHEN** _____

ARE YOU UP TO DATE WITH VACCINATIONS? **YES** ☐ **NO** ☐

PAST MEDICAL HISTORY: PLEASE CHECK ANY CONDITION THAT APPLIES TO YOU

HEART DISEASE	_____	ANEMIA	_____
HIGH BLOOD PRESSURE	_____	STOMACH PROBLEMS	_____
BLOOD TRANSFUSION	_____	HEPATITIS	_____
LUNG DISEASE	_____	DIABETES	_____
ENDOMETRIOSIS	_____	DEEP VEIN BLOOD CLOTS	_____
THYROID DISEASE	_____	OTHER MEDICAL PROBLEMS	_____

SURGICAL HISTORY: PLEASE PROVIDE DATE OF PROCEDURE

_____

_____

_____

_____

_____

FAMILY HISTORY: STATE WHO HAS THE DISORDER

BREAST CANCER_____
OVARIAN CANCER _____
OTHER CANCERS_____

DIABETES _____
HIGH BLOOD PRESSURE _____
BLOOD CLOTS/ DVT _____

ARE YOU CURRENTLY TAKING MEDICATIONS? YES ☐ NO ☐ IF YES, WHICH ONES?

_____

_____

ARE YOU CURRENTLY TAKING HORMONES? YES ☐ NO ☐ IF YES, WHICH ONES?

_____**HOW LONG?** _____

DO YOU SMOKE CIGARETTES? IF YES, HOW MANY A DAY _____

DO YOU DRINK ALCOHOL? NO ☐ OCCASIONALLY ☐ FREQUENTLY ☐

DO YOU USE: MARIJUANA ☐ COCAINE ☐ HEROIN ☐ OTHER STREET DRUGS ☐

DO YOU HAVE ANY OF THE FOLLOWING?

FREQUENT HEADACHES ☐ TROUBLE WITH EYES☐ TROUBLE WITH EARS ☐ NOSE BLEEDS ☐

WEIGHT CHARGES ☐ NAUSEA☐ VOMITING ☐ DIARRHEA ☐ CONSTIPATION ☐ SHORTNESS OF BREATH☐

COUGHING ☐ CHEST PAIN ☐ DIZZY SPELLS ☐ FATIGUE ☐ EASY BRUSING ☐ BLOODY STOOL ☐

LOSE OF URINE OR STOOL☐

PROLEMS WITH URINATION: BURNING ☐ URGENCY ☐ BLOODY ☐ PAINFUL UNRINATION ☐

Signature: _____ **Date:** _____

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Date_____

CONFIDENTIAL

Patient information

Last Name:		First Name:	
Middle Initial:		Sex:	Marital Status: M S D W
Current address:		Apt No:	City:
State:	ZIP Code:	SSN:	
DOB:	Home Phone:	Cell Phone:	
Age:	Email:	Occupation:	
Employed By:	Business Address:		Ste:
City:	Zip:	State:	Phone
Emergency Contact Name:		Emergency Contact Phone#:	
Language:		Race:	
Smoking Status:		Ethnicity:	
Referred By:		Primary Care:	
Pharmacy Name:		Pharmacy Address:	
City:	State:	Zip:	

GUARANTOR INFORMATION

Last Name:		First Name:	
Current Address:(if different from above)			Apt No:
City:		State:	
Zip:	SSN:	DOB:	
Age:	Email:	Occupation:	
Employed By:	Business Address:		
City:	State:	Zip:	Business Phone:

INSURANCE INFORMATION

Insurance ☐ Yes ☐ NO	Company:	
Subscriber:	Subscriber DOB:	Policy#:
Group#:	ID#	Code#:

Relationship: Spouse____ Child_____ Self_____ Other____

I hereby authorize my Doctor to furnish and disclose all known facts concerning my care to my insurance company and to other physicians for medical/and or billing purposes only. I hereby authorize my insurance company or fund to make payments directly to my Doctor or any insurance benefits otherwise payable to me for professional services, but not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company, or any charges not paid within sixty (60) days of billing the insurance company. A copy of this authorization will be a valid as the original.

Signature:_____ **Date**_____

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Patients Financial Agreement

IF YOU HAVE MEDICAL INSURANCE:
We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the Patient Information Form is current. If there are any changes in your insurance information please let us know immediately.

Deductibles, Co-Payments, and Coinsurance:
Co-payments are due at the time service is rendered. If you (patient) have a financial responsibility such as a coinsurance and/or deductible, payment is due at the time of service. Our office will only give an approximate amount of payment; and the estimated portion is due at the time of service. Any additional amount due after insurance adjustment is made is the patient responsibility.

Authorizations:
It is the patient's responsibility to provide our office with a current copy of your insurance card at the time of service. If the card is not available it is the patient's responsibility to pay at the time of service.

Providers/Referrals Coverage:
We are able to provide you with our list of providers and/or a referral. However, we are not responsible for ensuring that the provider is covered under your particular plan. It is your responsibility to verify that the provider is covered by your insurance prior to your visit. If the insurance company denies the claim, you will be responsible for the balance.

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are ultimately responsible for the timely payment of your account.

PAYMENT METHODS AND OTHER INFORMATION:
We accept cash, check and VISA or MasterCard.
Past due accounts can be set up on payment plans if necessary at no additional cost.
All late cancellations and no-shows will be billed $50 automatically. (We require 24-hour notice in advance to avoid charges.)

A SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

All Returned checks will have a $25.00 dollar service charge. All Future check privileges will be denied.

LAB AND X-RAYS
Laboratory fees are separate from this office. If you belong to an HMO or PPO and must use a specific facility for x-rays and laboratory services, please inform the nurse or the person ordering your test. THIS OFFICE IS NOT REPSONSIBLE FOR ANY LAB OR X-RAY PROCEDURE FEES. IT IS THE PATIENT'S REPSONSIBILTY TO INFORM OUR OFFICE OF WHICH FACILITY AND LABORATORY SHE/HE MUST USE.

Specify where to send your specimens: _____

Please be informed that this office in not accepting any Medi-cal patients.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy.

Signature: _____ Date: _____

Witness: _____Date: _____