RAMIN GHAYOORI, M.D., F.A.C.O.G.

Van Nuys Office
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Gynecology Questionnaire

Name _____ Date: _____ Date of Birth* _____
Age _____ Race* _____ Ethnicity* _____ Primary Language* _____
Cell Phone _____ Home Phone _____ Work Phone _____

If English is not your primary language, do you need a translator? (please circle) YES NO

Well Woman Update: (Please provide dates where applicable) Primary Care Provider (Doctor): _____

Last bone density exam _____(year)
Last colonoscopy _____(year)
Last mammogram _____(year)
Last Pap smear _____(month/year)
Last tetanus shot _____(year)
HPV/ Gardasil Vaccine series completed? ___ YES __ NO
Have you had the Hepatitis B series? ___ YES __ NO

Any abnormal Pap smears? _____YES____NO
Cervical Dysplasia (precancerous cells of the cervix)?
_____YES____NO
If yes, any treatment? Dates:
LEEP _____
Laser _____
Cryo (freezing) _____
Cone Biopsy _____

Medical History: Do you now have or have you ever had:

- ☐ Asthma
- ☐ Autoimmune disorder _____
- ☐ Bleeding Disorder
- ☐ Blood transfusion
- ☐ Bone/Joint Disease
- ☐ Cancer (type?) _____
- ☐ Chicken pox/shingles
- ☐ Chlamydia
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Elevated cholesterol
- ☐ Endometriosis
- ☐ Fibroids (type?)_____
- ☐ GERD/Reflux
- ☐ G.I. illness _____
- ☐ Gestational Diabetes
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ HIV
- ☐ HPV/genital warts
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pelvic inflamm. disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Syphilis
- ☐ Trauma
- ☐ Tuberculosis

Other: _____

Surgical History: Please list ALL surgical procedures, including year:

_____
_____
_____
_____
_____
_____

Anesthesia Complications: Please check those that apply.

- ☐ Excessive difficulty waking up
- ☐ Malignant Hyperthermia
- ☐ Difficult intubation

Medicines & Allergies:

Current medications & dosage _____
_____
Vitamins/ herbal supplements _____
Drug allergies _____
Reaction _____

Family History: Include the age of onset and type of cancer.

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other relative
Cancer (type)									
Diabetes (type)									
DVT									
Heart Disease									
Osteoporosis									

PLEASE COMPLETE BOTH SIDES

Reproductive History: Menstrual Cycle

Age at first period? _____ If menopausal, age of menopause: _____

How often do you get your menstrual cycle? Every _____ days, lasting ____ days.

Are your cycles? ☐ Regular ☐ Irregular

Are you sexually active? ☐ Never ☐ Not currently ☐ Yes

Method of contraception:

☐ Not Needed ☐ Vasectomy ☐ Rhythm Method ☐ Implanon ☐ Tubal Ligation
☐ None ☐ Condoms ☐ NuvaRing ☐ Mirena IUD ☐ Essure
☐ Pill ☐ Patch ☐ Depo Provera ☐ ParaGuard IUD ☐ Other_____

Obstetrical History

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.

Type: vaginal, C/S, forceps, or vacuum **Anesthesia**: epidural, local, general, spinal

Complications: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.

If preterm labor, were medications used?

PAST PREGNANCIES

	Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location
EXAMPLE:	01/15/75	40	12	6 lb. 2 oz.	F	Vaginal	Epidural	HBP. Gest. Diabetes.	HCGH

Social History

Occupation:_____

Are you? ☐ Married ☐ Single ☐ Engaged ☐ Significant other ☐ Divorced ☐ Widowed ☐ Same Sex Partner

Significant other's name: _____Phone#_____

Other emergency contact name: _____Phone # _____

Tobacco Use: ☐ Never ☐ Current___ # of Cigarettes per day ☐ Former, Quit at age ____

Any alcohol use? YES NO *If yes, the average number of drinks per week _____

Do you use street drugs? YES NO *If yes, the type used and last use _____

How many times and how long per week do you exercise? (circle) 1X 2X 3X 4X 5X+

Per session: 20 mins. 30 mins 45 mins 60+ mins

Do you eat a healthy diet? ☐ Daily ☐ Some ☐ No

Any history of violence or abuse in your current household or in your past? _____**NO**_____**YES**

Do you have any cultural or religious considerations that need special attention? _____**NO**_____**YES**

*****Subject to the needs of your health, a scheduled appointment may be changed by the provider to a different type of appointment.** _____ **(**Please Initial)

Patient signature_____ Date: _____

PLEASE COMPLETE BOTH SIDES

RAMIN GHAYOORI, M.D., F.A.C.O.G.

Patient Registration

PATIENT NAME: First	Last	DOB	AGE	CELL PHONE
HOME ADDRESS		CITY	STATE	ZIP CODE
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX	HOME PHONE
EMPLOYER	ADDRESS		WORK PHONE	
SPOUSE (OR PARENT)	SPOUSE (OR PARENT) EMPLOYER		SPOUSE (OR PARENT) WORK PHONE	
PRIMARY CARE PHYSICIAN	ADDRESS		TELEPHONE	

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME LAST NAME			RELATIONSHIP TO PATIENT
	EMPLOYER		WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS		POLICYHOLDER'S SOCIAL SECURITY	DATE EFFECTIVE
	POLICYHOLDER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	POLICYHOLDER'S ADDRESS		WORK PHONE	POLICYHOLDER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS		POLICYHOLDER'S SOCIAL SECURITY	DATE EFFECTIVE
	POLICYHOLDERS NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	POLICYHOLDER'S ADDRESS		WORK PHONE	POLICYHOLDER'S DATE OF BIRTH

HOW DID YOU HEAR ABOUT US?

☐ Physician ☐ Patient/Friend ☐ Internet ☐ Other:

BILLING POLICY AND PATIENT AUTHORIZATION

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, any unpaid balances are due within 30 days of receipt of the invoice. Payment is accepted in the form of cash, check, credit card, or money order. Accounts with balances open for more than 90 days may be charged interest on the unpaid balance at a rate of 12% per annum. If it is necessary to refer the account to our collection attorneys, the patient agrees to pay the cost of collection including attorney's fees of 25%.

I, the patient named above, hereby authorize Signature OB/GYN to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing-agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care.

As the patient or parent or guardian, I agree to the above terms and conditions.

Date: _____ Signature of Patient or Parent or Guardian _____

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USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. Ramin Ghayoori, MD will not condition treatment by your failure to sign this disclosure.

By signing this disclosure I acknowledge that Ramin Ghayoori, MD may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered. I am aware that Ramin Ghayoori, MD may disclose my medical information to a *Business Associate* for the same reasons, and that the *Business Associate* will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA.

Acknowledged and agreed to by:

Patient: _____ or Representative: _____

Signature: _____ Date: _____

The Federal Government now restricts this office and Ramin Ghayoori, MD from discussing your health information and condition with other family members or person unless you specifically give your written permission.

By my signature below, I grant Ramin Ghayoori, MD permission to discuss my protected medical information with the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient: _____ Date _____

Please list daytime telephone number(s) at which you prefer to be reached.

_____

Can we leave a message regarding your protected health information at the number(s) you have provided? ( ) Yes ( ) No

RAMIN GHAYOORI, M.D., F.A.C.O.G.

Obstetrics Questionnaire

PLEASE, FILL OUT ONLY IF CURRENTLY PREGNANT

Name: _____ Date of Birth :_____

Father of Baby's Name: _____

How old will you be by your due date? ____ years old.

Have you have had chicken pox or shingles or have been vaccinated for chicken pox? YES NO

Is this pregnancy the result of infertility treatments? YES NO If so, what kind? _____

Are you interested in screening for birth defects and chromosomal abnormalities (ultrasound and blood tests offered to all pregnant women)? YES NO MAYBE

Do you want a blood test to determine if you carry the gene for:

Cystic Fibrosis (Caucasian and Jewish patients at highest risk)? YES NO
Sickle Cell Disease (African-American and Hispanic patients at highest risk)? YES NO
Tay Sachs Disease (Jewish patients at highest risk)? YES NO

For both you and the father of the baby, is there a family history of:

Mother's Family	Father's Family		Mother's Family	Father's Family	
☐	☐	Children who died before birth or shortly after	☐	☐	Mental retardation
☐	☐	Cystic Fibrosis	☐	☐	Muscular Dystrophy
☐	☐	Diabetes	☐	☐	Neural tube defects
☐	☐	Downs Syndrome	☐	☐	Tay Sachs Disease
☐	☐	Hemophilia	☐	☐	Thalassemia
☐	☐	Huntington's Chorea	☐	☐	Other Chromosomal disorders or birth defects

First day of your last menstrual period. _____
Was it normal? YES NO
How far apart are your menstrual cycles? _____ Days
Are they regular or irregular? _____
Date of positive pregnancy test? _____
Was this pregnancy conceived on birth control pills? YES NO

I am of the following ethnicity: (please circle)
Asian African-American Caucasian French-Canadian Jewish Hispanic Mediterranean Other

The father of the baby is of the following ethnicity: (please circle)
Asian African-American Caucasian French-Canadian Jewish Hispanic Mediterranean Other

Do you own a cat? YES NO Who changes the litter box? _____

HIV testing will be done with your routine labs.

Patient's signature: _____ Date: _____

Last Update: August, 9, 2014