Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

Medical History Data Base

Please complete all items. If is not applicable, please write N/A.

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Ethnic/Racial Background: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender Identity: ☐ F ☐ M ☐ X _____

Occupation: _____ Referred by: _____

A. PERSONAL MEDICAL HISTORY:

1. List medications you are currently taking: _____
2. List any allergic/reaction you've had to any drug, medication or other substance _____
3. Have you ever had or needed treatment for: Clinician's Notes:

Anemia/Sickle Cell Anemia	☐ Yes	☐ No	Date _____
Bladder Problems (Incontinence)	☐ Yes	☐ No	Date _____
Blood Clots	☐ Yes	☐ No	Date _____
Bowel Problems (Colitis)	☐ Yes	☐ No	Date _____
Breast Disease	☐ Yes	☐ No	Date _____
Cancer	☐ Yes	☐ No	Date _____
Elevated Blood Sugar (Diabetes)	☐ Yes	☐ No	Date _____
Heart Problems (murmurs/surgery)	☐ Yes	☐ No	Date _____
High Blood Pressure (Hypertension)	☐ Yes	☐ No	Date _____
High Cholesterol	☐ Yes	☐ No	Date _____
Kidney Disease (UTI)	☐ Yes	☐ No	Date _____
Liver Disease (Hepatitis)	☐ Yes	☐ No	Date _____
Lung Disease (TB, Asthma)	☐ Yes	☐ No	Date _____
Neurologic Problems (Epilepsy)	☐ Yes	☐ No	Date _____
Psychiatric Problems	☐ Yes	☐ No	Date _____
Severe or Frequent Headaches	☐ Yes	☐ No	Date _____
Stomach Problems (Ulcers)	☐ Yes	☐ No	Date _____
Stroke or Stroke-like Problems	☐ Yes	☐ No	Date _____
Thyroid Problems	☐ Yes	☐ No	Date _____
Other	☐ Yes	☐ No	Date _____

B. GYNECOLOGIC HISTORY:

Menstrual History: (if in menopause, skip to next section)

1. The first day of my last menstrual period (date): _____
2. My period usually comes every _____ days (example: once a month = 28 – 30 days)
3. When I have my period, it usually lasts _____ days.
4. Do you have any problems related to your period? ☐ No ☐ Yes

   If yes, please explain _____
5. Do you have pain/cramps with your period? ☐ No ☐ Yes
6. How old were you when you had your first period? _____

Menopausal History:

1. Year menopause began (date of your last period): _____
2. Any bleeding since menopause? ☐ No ☐ Yes
3. Any problems with the following?

Vaginal Dryness	☐ No	☐ Yes
Hot Flashes	☐ No	☐ Yes
Urination	☐ No	☐ Yes
Bowel Movement	☐ No	☐ Yes

General Gynecology History:

1. Are you sexually active? ☐ No ☐ Yes Current Sexual Partner(s): ☐ Male ☐ Female ☐ Both ☐ Other
2. Do you have other symptoms or problems related to sex? ☐ No ☐ Yes Explain _____
3. Age at first intercourse? _____
4. Current method of birth control _____

Please continue questions on the back of this form ⟶

5. What other methods of birth control have you used? _____
6. Have you ever had any of the following? (check all that apply)

☐ Trichomonas ☐ Herpes ☐ Condyloma (genital warts) ☐ HIV
☐ Gonorrhea ☐ Syphilis ☐ Bacterial Vaginitis ☐ Chlamydia

7. Have you ever had an infection of the uterus, tubes or ovaries? ☐ No ☐ Yes
8. Have you ever had any of the following? (check all that apply)

☐ History of gynecological disease such as fibroids, endometriosis, etc. Explain _____
☐ Abnormal mammogram Date _____ ☐ Abnormal pap smear Date _____
☐ Colonoscopy Date _____ ☐ Cryotherapy/LEEP Date _____
☐ Colposcopy Date _____

9. Date of last bone density (DEXA) _____ Result _____
10. Date of last pap smear? _____ Result _____
11. Date of last mammogram? _____ Result _____ Location _____
12. Date of last cholesterol test? _____ Result _____ Location _____
13. Date of last diabetes screening? _____ Result _____ Location _____

C. OBSTETRICAL HISTORY: Please list all pregnancies.

Year	Vaginal or C-Section	Miscarriage	Abortion	Boy or Girl	Problems/Complications	Hospital Name

D. SURGERY AND HOSPITALIZATION HISTORY:

Year	Surgery	Hospitalization	Problem(s)

E. SOCIAL HISTORY:

Do you

Smoke/Vape (Currently or Previously) ☐ No ☐ Yes Amt/Day ____ # years use ____
Drink Alcohol ☐ No ☐ Yes Frequency ____ # years use ____
Use Illicit/Recreational Drugs ☐ No ☐ Yes Frequency ____ # years use ____ Type____
Exercise Regularly ☐ No ☐ Yes How often _____
Have a history of abuse? ☐ No ☐ Yes Type of abuse _____

F. FAMILY MEDICAL HISTORY:

Do any of your relatives have the following?

Medical Illness	Yes	No	Maternal (Mom's side)	Paternal (Dad's side)
Bleeding Disorder				
Cancer				
Diabetes				
Heart Disease				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Stroke				
Thyroid Disease				
Tuberculosis				
Other				

☐ Unsure (Adopted)

By signing below, I certify the information I have provided to Hawaii Women's Healthcare is accurate and complete to the best of my knowledge.

Patient's Signature_____ Date _____

Physician's Signature _____ Date _____

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Patient Information

Patient Name (Last, First, Middle)			Date of Birth	Social Security Number
Patient Address			City, State, Zip Code	
Primary Phone Number	Cell Phone Number		E-mail Address	
Marital Status	Are you a student? Full or Part Time?	How were you referred to us?		
Employer		Occupation		Work Number
Person responsible for the bill		Relationship to you		Phone Number
Billing Address			City, State, Zip Code	
Emergency Contact	Relationship to you	Phone Number	Address	
Patient's Signature			Date	

Insurance Information

Primary Insurance Company	Policy Number		Coverage Code	Group Number
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security Number		Effective Date
Subscriber's Employer	Subscriber's Occupation		Subscriber's Work Number	
Insurance Mailing Address				
Secondary Insurance Company	Policy Number		Coverage Code	Group Number
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security Number		Effective Date
Subscriber's Employer	Subscriber's Occupation		Subscriber's Work Number	
Insurance Mailing Address				

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____
(Patient's Name) (Name of insurance company)

to pay and hereby assign directly to **Lauren Sword, D.O.** all benefits, if any, otherwise payable to me for services.
I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to

Lauren Sword, D.O. will be credited to my account, in accordance with the above said assignment.

Subscriber's signature_____ Date _____

Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

Cheryl Lynn T. Rudy, M.D.
Cheryl L. Leialoha, M.D.
Erin C. Gertz, M.D.

Saki Onda, M.D.
Ding Ding Kelly Lee, M.D.
Lauren Sword, D.O.
Andrea Wieland, APRN, IBCLC

Welcome to Hawaii Women's Healthcare

Hawaii Women's Healthcare strives to provide you with the best medical care possible. We are dedicated to caring for women in all phases of their lives. For many women, having a female physician can be comforting when dealing with sensitive women's health issues. We understand your concerns from a woman's point of view. We are strong advocates on many women's health care issues and are dedicated to improving the quality of medical care for women in our community.

- **Payment** – Payment is requested on the day of service. This will enable us to minimize the cost of billing and postage thus keeping our medical fees to a minimum. We accept cash, checks and credit cards. There is a $10.00 billing fee if payment is not received on the day of service. Delinquent payment after 90 days will be referred to our collection agency. There is a $25.00 collection fee if your account is referred to our collection agency. If you are having financial difficulties, please contact our office.

- **Appointments** – We have set aside time for your visit which may prevent others from being seen that day. **You may be assessed up to a $50.00 no-show fee if you fail to keep your appointment or cancel less than 24 hours from your scheduled appointment time.** Please arrive for your appointment no later than 15 minutes before your appointment time for optimum patient flow. **Due to the nature of our specialty, the physician may be called out of the office for an emergency. At this time, you will have the option to reschedule your appointment or returning for a later appointment.**

Authorization to release information and insurance payments

I request payment of authorized Medicare and/or other insurance company benefits be made to me or on my behalf to **Lauren Sword, D.O.** for any services furnished to me by that physician. I authorize any holder of medical information about me to release it to the above insurance carriers or to the Health Care Financing Administration and its agents if required, any information needed to determine these benefits or the benefits payable for related services which may include information on sexually transmitted diseases and HIV. I understand that I am responsible for any amount not covered by my insurance.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Hawaii Women's Healthcare
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Cheryl Lynn T. Rudy, M.D.
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HIPAA Patient Privacy Acknowledgement Form

I consent to the use or disclosure of my protected health information by Lauren Sword, D.O. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Lauren Sword, D.O. I understand that diagnosis or treatment of me by Lauren Sword, D.O. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lauren Sword, D.O. is not required to agree to the restrictions that I may request. However, if Lauren Sword, D.O. agrees to the restriction that I request, the restriction is binding on Lauren Sword, D.O.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lauren Sword, D.O. has taken action in reliance on a government agency directive as outlined in the Notice of Privacy Practices.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Lauren Sword, D.O. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lauren Sword, D.O. The Notice of Privacy Practices for Lauren Sword, D.O. is provided at Hawaii Women's Healthcare, LLC. This Notice of Privacy Practices also describes my rights and Lauren Sword, D.O. duties with respect to my protected health information.

Lauren Sword, D.O. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Legal Representative (Parent) Date

_____

Print Name of Patient and Print Name of Legal Representative

_____

Description of Legal Representative's Authority

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CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that, in order for Hawaii Women's Healthcare, LLC staff to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give permission for them to do so.

Consent for Leaving Messages

I give my permission for messages to be left on my phone number(s) below:

O Cell# _____ O Home # _____ O Work #_____

O I prefer not to have voice mail messages from the clinic

Regarding the following:

O Appointment Reminders/Changes O Account Payments/Balances O Cost Estimates

O Needed Treatment/Completed Treatment

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law, we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Dr. Cheryl Leialoha, Dr. Cheryl Lynn Rudy, Dr. Erin Gertz, Dr. Saki Onda, Dr. Ding Ding Kelly Lee, Dr. Lauren Sword, Andrea Wieland, APRN, IBCLC and their representatives at Hawaii Women's Healthcare, LLC to verbally discuss my care using their best judgment and grant them permission to disclose medical information that is relevant to my care or relevant for payment. O Yes O No

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

Regarding the following:

O Appointment Reminders/Changes O Account Payments/Balances O Cost Estimates

O Needed Treatment/Completed Treatment

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____ _____ _____

Printed Name (Patient/Parent) Signature (Patient/Parent) Date