

# Dr. Anna Cabeca D.O. Gynecology Obstetrics Infertility

## Medical History Update

Welcome back. We would like to update any relevant changes to your health history that may have occurred since our last annual or comprehensive visit. Please take a few minutes to complete this form and give it to your physician.

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

CURRENT OCCUPATION \_\_\_\_\_ Marital Status: S M D W (Circle one)

Reasons for today's visit: (please check all those which apply)

Annual examination

Abdominal pain

Irregular period

Menopausal symptoms

Contraception consultation

Planning pregnancy

Problems with intercourse

Other \_\_\_\_\_

No problems

abnormal bleeding

unusual discharge

Premenstrual syndrome

Breast problems

Infertility

Vitamin Therapy

Your current method of birth control is \_\_\_\_\_ Sterilization \_\_\_\_\_ No current need \_\_\_\_\_

Have you been pregnant since your last visit: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Your other health doctors are: (Please list all excluding dentist) \_\_\_\_\_

Current medications are: (please list all including birth control pills, vitamins and herbs):

Allergies to Medications \_\_\_\_\_

List type and dates of any hospitalization, surgery or major medical illness since your last annual visit:

Have any of your immediate family (mother, father, sisters, brothers, grandparents, aunts, uncles) had any major illness or died since your last annual visit: \_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, please describe:

Are you being physically, emotionally or sexually abused? \_\_\_\_\_ Yes \_\_\_\_\_ No

Alcohol/glasses per week: \_\_\_\_\_

Calcium servings per day: \_\_\_\_\_ Supplements/mg. per day: \_\_\_\_\_

Tobacco: \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ Packs per day \_\_\_\_\_

Exercise: Type: \_\_\_\_\_ minutes per session: \_\_\_\_\_ Times per week: \_\_\_\_\_

Caffeine: \_\_\_\_\_ cups per day

Street drugs (i.e. Marijuana, Cocaine, etc.) \_\_\_\_\_ Yes \_\_\_\_\_ No

Last tetanus shot (year) \_\_\_\_\_

Last mammogram (month, year) \_\_\_\_\_ Do you perform monthly self breast exams? \_\_\_\_\_ Yes \_\_\_\_\_ No

## Information and Waiver of Laboratory Testing

**Your insurance does not necessarily pay for all of your health care costs. Your insurance only pays for covered items and services when your insurance rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There is a good reason your doctor recommended it.**

The Pap Smear is a screening test for cervical cancer. If you have a uterus/cervix we use a liquid based thin-prep pap priced at \$70 and without a uterus we use the glass slide priced at \$45. If either test comes back abnormal (ASCUS) we automatically send it for testing for the High Risk Human Papilloma Virus to enable us to better determine your risk of cervical disease and treatment and follow-up. The additional lab charges are billed to your insurance.

The purpose of this form is to help you make an informed choice about whether or not you want to receive laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

Ask us to explain, if you don't understand why your insurance might not pay.

Ask us how much these laboratory tests will cost you (**Estimated Cost: \$ \_\_\_\_\_**).

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN AND DATE YOUR CHOICE.**

\_\_\_\_ Option 1. **YES. I want to receive these laboratory tests.** I understand that my insurance may decide not to pay for these laboratory tests. Please submit my claim to my insurance. I understand that you may bill me for laboratory test and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.

\_\_\_\_ Option 2. **NO. I have decided not to receive these laboratory tests.** I will not receive these laboratory tests. By waiving these laboratory tests, I am aware that I may have an undiagnosed pathology or illness that may otherwise have been detected.

\_\_\_\_ Option 3. **PARTIAL. I want to receive part of these laboratory tests.** By waiving part of these laboratory tests, I am aware that I may have an undiagnosed pathology or illness that may otherwise have been detected.

***Please note, our rates reflect a discounted rate given to us by the laboratory. We do our best to keep the laboratory charges as low as possible.***

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or person acting on patient's behalf

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness