Patient Satisfaction Survey

Don't bother travelling to New York. Now, the high quality treatments which are a routine part of women's health internationally have come to you. Whether you need a simple check-up or 21st Century technologies, both are as close as your next appointment.

Intrauterine Insemination

Treatment of Polycystic Ovaries

Evaluation of Pelvic pain

Office Hysteroscopy

Permanently Treat Heavy Bleeding with Endometrial Cryoablation

Birth Control

Prenatal Care

Prevention of Preterm Birth with 17-alpha-hydroxy-progesterone

Prevention Cervical Cancer & Warts with Gardasil HPV Vaccine

Colposcopy, LEEP and more

252 Glynn; RR1 #6196

Kingshill, VI 00850

appointments@drmamouzette.com

(800) 516-4090

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age: _____ Your Sex: (M) (F)

Please circle how well you think we are doing in the following areas:

	GREAT	GOOD	OK	FAIR	POOR
Ease of getting care:					
Ability to get in to be seen	5	4	3	2	1
Hours Center is open	5	4	3	2	1
Convenience of location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
Waiting:					
Time in waiting room	5	4	3	2	1
Time in exam room	5	4	3	2	1
Waiting to have tests	5	4	3	2	1
Waiting for test results	5	4	3	2	1
Staff:					
Provider: (Physician, Dentist, Physician Assistant, Nurse Practitioner)					
Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives good advice/treatment	5	4	3	2	1
Nurses and Medical Assistants:					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
All Others:					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
Payment :					
What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
Collection of payment	5	4	3	2	1
Facility:					
Neat and clean building	5	4	3	2	1
Ease of finding where to go	5	4	3	2	1
Comfort and Safety waiting	5	4	3	2	1
Privacy	5	4	3	2	1
Confidentiality:					
Keeping information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us:	5	4	3	2	1

What do you like best?_____

What do you like least about our center?_____

Suggestions for improvement? _____

Thank you for completing our Survey!

DrMamouzette.com

Ob-Gyn & Infertility

Patient Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact : Moise Mamouzette at (340)692-6263. This notice describes the privacy practices at our office. We are required by law to:

* Maintain the privacy of protected health information
* Give you this notice of our legal duties and privacy practices regarding your health information
* Follow the terms of the notice currently in effect.

How we may use and disclose your health information Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Moise Mamouzette. Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance. National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to Moise Mamouzette.

Right to Amend. You have the right to request an amendment to your records by written request to Moise Mamouzette.

Right to an Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Moise Mamouzette.

Right to Request Restrictions. You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Moise Mamouzette. We are not required to agree with your request, but we will try to comply. Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Moise Mamouzette. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to privacy@drmamouzette.com, or,

Moise Mamouzette, MD
252 Glynn; RR1 #6196
Kingshill, VI 00850 (340)692-626

Patient Bill of Rights

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Essure® Permanent Birth Control

Intrauterine Insemination

Treatment of Polycystic Ovaries

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Prenatal Care

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A patient has the right to:

- Be treated with courtesy, respect, and with appreciation of his/her dignity, and with protection of his/her need for privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his/her care.
- Know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- Know what rules and regulations apply to his/her conduct.
- Be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges of care.
- Receive a copy of a reasonably clear and understandable, itemized bill and upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- To access any treatment that is in his/her own judgment and the judgment of his/her health care practitioner in the best interests of the patient including complimentary or alternative health care treatments, designed to provide an effective option to conventional treatments.
- Treatment for any emergency condition that will deteriorate without treatment.
- Have his/her reports of pain addressed promptly.
- Know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such experimental research.
- Express grievances regarding any violation of his/her rights, as stated in Virgin Islands law, through the grievance procedure of the health care provider or health care facility which served him/her and to the appropriate state licensing agency.

A patient is responsible for:

- Providing the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- His or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

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Ob-Gyn & Infertility

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FAX 340-692-6263

*Patient's Name:*_____
DOB:_____

HIV Counseling Form

PRE-TEST COUNSELING	YES	NO
Basic information on HIV and AIDS facts and treatment	☐	☐
Transmission	☐	☐
Prevention	☐	☐
Benefits of testing	☐	☐
Use of condoms	☐	☐
Cleaning needles (if appropriate)	☐	☐
Testing options	☐	☐
HIV test and results psychological & emotional consequences	☐	☐
Confidentiality	☐	☐
Discrimination	☐	☐
Partner notification	☐	☐
Literature given if requested	☐	☐

*Patient's decision:*_____
*Reason for refusal:*_____
*Referred for anonymous testing:*_____
*Testing date:*_____
*Comments:*_____

_____ _____
Signature *Date*

HIV Post Testing Counseling

POST-TESTING COUNSELING	YES	NO
Provide test results	☐	☐
Review prevention	☐	☐
Review condoms and needles	☐	☐
Encourage Partner notification	☐	☐
Review confidentiality, disclosure and discrimination	☐	☐
Literature provided if requested	☐	☐

*Follow-up plan:*_____
*Referrals (if necessary):*_____
*Status of partner notification:*_____
*Comments:*_____

_____ _____
Signature *Date*

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*Patient's Name:*_____
DOB:_____

Initial Lifestyle Profile

Write down below what you eat for each time period:

Breakfast:	*Lunch:*	*Dinner:*	*Snacks:*
Fluids:	*Fluids:*	*Fluids:*	*Fluids:*

Education:	*Occupation:*	*Work phone number:*
Patient:		
Father of baby:		

Nutritional Assessment: ☐ *Yes*	*Nutritional Status:* ☐ *Well nourished* ☐ *Obese*	*Eating disorders:*
☐ *No*	☐ *Malnourished* ☐ *Other*	☐ *Anorexia* ☐ *Bulimia*

Answer the following questions:

Do you eat a special diet (i.e. vegetarian, diabetic)? ☐ *No* ☐ *Yes*_____
Do you use artificial sweeteners? ☐ *No* ☐ *Yes*_____
Do you have any food intolerance/allergies? ☐ *No* ☐ *Yes* _____
How much caffeine do you take per day? ☐ *None* ☐_____
Are you taking any vitamins? ☐ *No* ☐ *Yes What kind?*_____ *How many per day?*_____
Do you eat raw fish or meat? ☐ *No* ☐ *Yes, How often?*_____ *Other*_____

Activity Assessment:

	No	*Yes*
Job outside home	☐	☐
Work at home	☐	☐
Frequent travel	☐	☐
Commute ≥ 2hrs per day	☐	☐
Exercise	☐	☐
Leisure Activities	☐	☐
Other	☐	☐

Comments:

Sexuality Assessment:

Partners ☐ *One* ☐ *other*
Physical changes: ☐ *None*
Identify:

Psychological changes: ☐ *None*
Identify:

Other:

Psycho/Social Assessment:

Basic Needs Met	*No*	*Yes*
Housing	☐	☐
Clothing	☐	☐
Food	☐	☐
Finances	☐	☐
Transportation	☐	☐
Life Stress		
Physical abuse	☐	☐
Emotional abuse	☐	☐
Major change	☐	☐
Serious illness or death	☐	☐

Comments:

Social Support	*No*	*Yes*
Biological Father Involved	☐	☐
Others available	☐	☐
Adaptation to Pregnancy		
Planned pregnancy	☐	☐
Lifestyle modifications	☐	☐
other:		

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*Patient's Name:*_____
DOB:_____

Prenatal Labs and Visits Flow Sheet

Final EDD:

*EDD by LMP:*_____ *EDD by sono:*_____ *GA @ sono:*_____ *Date of sono:*

Date	Test	Result	Date	Test	Results
	Type / Rh			***15-22 wks***	
	Rh antibody			*AFP*	
	Hgb/Hct			*Fetal Anatomy US*	
	Sickle Screen			***26-28 wks.***	
				Rhogam	
	VDRL/RPR			*Hgb/Hct*	
	Rubella titer			*GCT 1hr*	
	Varicella			*GTT 3hr FBS*	*1°*
	HBsAG			*2°*	*3°*
	HIV			*Urine culture*	
	Urinalysis			***34-38 wks.***	
	Pap			*GBS Cx.*	
				Gonorrhea	
				Chlamydia	

Date: MO/DY	Weeks Gestation (best est)	Fundal Height	Presentation	HA, Blurred Vision	Edema of hands or face	Weight	Blood Pressure	Urine Prot./Leuk.	FHR Fetal Movement	Preterm Labor Signs/Symptoms: +=present 0=absent	Cervix Exam (Dilation/Eff./)	Next Appointment	Provider Initials	Comments:

MMMD
*Initial Chart sent:*_____

*Physician Signature:*_____
*Final Chart:*_____

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*Patient's Name:*_____
DOB:_____

Prenatal Problem List

Condition	Treatment/Comment/Meds	Start	Stop
1	1		
2	2		
3	3		
4	4		
5	5		
6	6		

	GDM								HTN			Asthma	PTL/CI		Thyroid		Other		
	BGM: (% abnormal)					Rx													
Date	FBS	2hpB	2hpL	2hpD	HS	R/N	R	N	24h Uprot	ClCr	MBP	PEFR	Cervix Length 76817	FFN	TSH	FT4			

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*Patient's Name:*_____
DOB:_____

Date:_____

To whom this may concern:

Please be advised that _____is following treatment with our office for prenatal care. Her expected due date is _____.
If you have any questions, please feel free to contact our office.

Likewise, she will be medically on "maternity leave from _____*(date)* until _____*(date)*.

Thank you,

_____
Moise Mamouzette, MD

NOTICE:

IT IS COMMON FOR WORKING WOMEN TO DESIRE TO CONTINUE TO WORK AFTER 36 WEEKS OF PREGNANCY, OR RETURN TO WORK BEFORE SIX WEEKS OF CONVALESCENCE. THE ABOVE DATES OF MATERNITY LEAVE ARE INTENDED FOR INFORMATION PURPOSES AND ARE SUBJECT TO THE PATIENT'S JUDGEMENT AND CURRENT CONDITION.

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*Patient's Name:*_____
DOB:_____

*Date:*_____

GENETIC SCREENING/ TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENTS AGE≥ 35 YEARS			12.MENTALRETARDATION/AUTISM		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND):MCV<80			IF YES, WAS THE PERSON TESTED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. CONGENTIAL HEART DEFECT			14. MATERNAL METABOLIC DISORDER (EG, INSULIN DEPENDENT DIABETES, PKU)		
5. DOWN SYNDROME			15. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6. TAY-SACHS 9EG, JEWISH, CAJUN, FRENCH CANADIAN)			16. RECURRENT PREGNANCY LOSS, OR STILLBIRTH		
7. SICKLE CELL DISEASE OR TRAIT(AFRICAN)			17. MEDICATIONS/STREET DRUGS/ ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. HEMOPHILIA			IF YES, AGENT(S):		
9. MUSCLUR DYSTROPHY			18. ANY OTHER		
10. CYSTIC FIBROSIS					
11. HUNTINGTON CHOREA					

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*Patient's Name:*_____
DOB:_____

Pre-natal Education:

Maternal	**Reviewed**	**Comments**
Environmental Hazards		
Avoidance of harmful practices and substances including alcohol, nonprescription drugs, medications, nicotine, and toxoplasmosis precautions.		
Rights and responsibilities of the pregnant woman.		
Diet & Nutrition		
Physical and sexual activities		
Signs of complications of pregnancy		
Preeclampsia Precautions		
Orientation of the place of delivery		
Risk of HIV infection and risk reduction behavior		
Benefits of Prenatal HIV testing		
AFP (Alpha-feto Protein) Pre-testing		
Results Reviewed:		
Amniocentesis		
Labor & Delivery procedures		
Relaxation process in labor		
Child Birth classes		
Obstetrical anesthesia & analgesia		
Post-partum birth control		
Tubal sterilization *Consent signed: ☐ yes ☐ no* *Date:*	*Initials of witness:*	
VBAC		
Travel		
WIC referral		
Other		
Infant:		**Comments**
Preparation for parenting including: *☐Infant growth & development* *Feeding options:☐ breast☐bottle*		
Universal testing of newborns for HIV through newborn screening program		
Newborn Car Seat		
Circumcision		
Other		

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*Patient's Name:*_____
DOB:_____

OVER THE COUNTER MEDICATIONS SAFE DURING PREGNANCY AND/OR BREASTFEEDING

Nausea	*To prevent morning sickness, eat several small meals daily, drink liquids between meals rather than with meals, avoids fried and greasy foods. Before getting out of bed in the morning, eat dry bread or cracker and then get up slowly. Take a walk in the fresh air, soda water, ginger ale, spearmint, peppermint or raspberry tea after vomiting may be helpful. Call if vomiting persists or is prolonged. Motion sickness bracelets are available at your local pharmacy for this type of nausea.*
Hemorrhoids	*Anusol suppositories or cream, Preparation H, Tucks pads*
Constipation	*Metamucil and extra fluids (water), Fibercon, Peri-Colace, Colace, Surfak, increase fiber in diet.*
Headache, Fever or Pain	*Tylenol or Extra-Strength Tylenol (DO NOT take Advil, Ibuprofen or any medication containing aspirin)*
Diarrhea	*Kaopectate, Imoduim AD, Donatol, Donagel, Pepto Bismol*
Heartburn / Indigestion	*Maalox, Mylanta II , Tums, Rolaids*
Colds	*Tylenol or Tylenol Cold & Sinus, Sudafed, or Actifed*
Cough	*Robitussin DM cough syrup, Triaminic (expectorant or DM)*
Nasal Congestion	*Afrin, Ornex, Neo-Synepherine nose drops or spray, Saline nose drops, Benadryl*
Allergy	*Tylenol Cold, Sudafed plus, Benadryl, Clor Trimeton*
Sore Throat	*Gargle with warm salt water, Chloraseptic Spray, Lozenges*
Yeast Infection	*Monistat vaginal cream, Gyne-Lotrimin vaginal cream*
Skin Itching or irritation	*Hydrocortisone 0.5% cream or ointment*

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*Patient's Name:*_____
DOB:_____

Current Date_____

Post Partum Visit Summary

Delivery and Newborn Information:

*Normal Vaginal Delivery ☐ C-Section ☐ Date:*_____
*Any complications with the delivery?*_____*Date of last period:*_____
*Did you have a boy or a girl? Birth weight:*_____
*Bottle or Breast feeding?*_____

Maternal Information:

*Have you been sexually active since the delivery?*_____
*Do you desire birth control?*_____*Type/Method:*_____
*Any problems or concerns at this time?*_____
_____
*Any changes in your mood, crying spells or insomnia?*_____

Physical assessment:

*Height:*_____ *Weight:*_____*BP*_____*Pulse*_____*Resp*_____*Temp*_____
*Skin: ☐WNL's ☐Abn*_____*Neurologic: ☐WNL's ☐Abn*_____
*Extremities: ☐WNL's ☐Abn*_____*HEENT Fundi ☐WNL's ☐Abn*_____
*Neck/ Thyroid: ☐WNL's ☐Abn*_____*Breast/ nipples: ☐WNL's ☐Abn*_____
*Cardiovascular: ☐WNL's ☐Abn*_____*Respiratory: ☐WNL's ☐Abn*_____
*Abdomen: ☐WNL's ☐Abn*_____*Gastrointestinal: ☐WNL's ☐Abn*_____
*Back: ☐WNL's ☐Abn*_____*Reflexes: ☐WNL's ☐Abn*_____
*Other:*_____

Pelvic:

*External Genitalia: Vulva: ☐WNL's ☐Abn*_____*Vagina ☐WNL's ☐Abn*_____
*Cervix: ☐WNL's ☐Abn*_____*Uterus Size:*_____
*Adnexa: ☐WNL's ☐Abn*_____*Rectum: ☐WNL's ☐Abn*_____
*Pelvic type: ☐gynecoid ☐nongynecoid Type:*_____

Impression/Assessment:

_____
_____

Problems identified: ☐NONE ☐ Yes

*1.*_____
*2.*_____
*3.*_____

Plan: *1.*

*2.*_____
*3.*_____

*Physician Signature:*_____

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*Patient's Name:*_____
DOB:_____

DEMOGRAPHIC INFORMATION

Patient Name:_____ *Age:*_____ *Date of Birth:*_____
Mailing Address:_____
(STREET) *(CITY)* *(STATE)* *(ZIP)*
Social Security Number:_____
Patient's Sex: *Female* ***Married*** ***Single*** ***Widowed*** ***Divorced***
Employed: *F/T P/T Retired Student*

Patient Employer:_____ ***Work Telephone:***_____
Home Telephone:_____ ***Cell phone:***_____
Email Address_____

May we contact you at work if necessary?_____
Another number where you could be reached in case of emergency?_____
Primary Care Physician:_____ ***Pharmacy:***_____

Primary Insurance Co. Name:_____ ***Telephone:***_____
Address:_____
ID No.:_____
Group No.:_____ ***CoPayment amount:***_____
Guarantor's Name:_____ ***Insured's Date of Birth:***_____
Patient's relationship to guarantor? *self spouse child other*

Secondary Insurance Co. Name:_____ ***Telephone:***_____
Address:_____
ID No.:_____
Group No.:_____ ***CoPayment amount:***_____
Guarantor's Name:_____ ***Insured's Date of Birth:***_____
Patient's relationship to guarantor? *self spouse child other*

AUTHORIZATION

I authorize release of any information necessary to process my Insurance claims and assign and request payment directly to my physicians. I understand that I am financially responsible for all charges incurred for services rendered to me. I agree to accept full responsibility for payment to include the balance remaining after the payment of possible Insurance benefits.

*X*_____ *Date:*_____
Signature of Patients or Responsible Party

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*Patient's Name:*_____
DOB:_____

Summary Sheet

Problem	ICD	Active	Inactive

Medication and Dosage	Sig	#	Refill	Initiated	Last Refill	Comments	Previous Refills

Date	PAP Smear	GC	Chlam	Weight	BP	Clinical Breast Exam	Mammo-gram	Colorectal Screening			

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*Patient's Name:*_____
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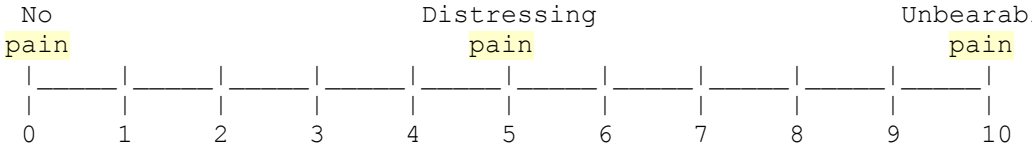
0-10 Numeric Pain Distress Scale [1]



Flowsheet for Pain Management Documentation

DATE	PAIN RATING	ANALGESIC	HR	BP	LEVEL OF AROUSAL	OTHER	PLAN & COMMENTS

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*Patient's Name:*_____

DOB:_____

Current Date:

Reason for visit: (Required for all visits) ☐ Annual GYN[V72.3] ☐ Pain[789.03, 4] ☐ Bleeding[626.8] ☐ Swelling ☐ Discharge[616.11]

☐ Other:

On or about:_____date, this patient began having ☐ pain ☐ bleeding of (location).

Pain is ☐ sharp ☐ dull, ☐ constant ☐ intermittent, which occurs during_____(context)

made worse by_____ better by_____.

The pain ☐ does not travel ☐ travels to _____(location). Severity is _____out of ten(10)

and is associated with: (circle) nausea vomiting diarrhea constipation frequency urgency nocturia dysuria

Other features:

Are you experiencing any of these symptoms:

Symptom	*yes*	*no*	**Symptom**	*yes*	*no*	**If yes please provide more details.**
No period[626.8]	☐	☐	Change in mood, crying, sleeping disturbances, insomnia)	☐	☐	
Mid-Cycle bleeding	☐	☐	Belly getting bigger	☐	☐	
Clots with periods	☐	☐	Bleeding after menopause	☐	☐	
Bleeding with urination	☐	☐	Leaking urine with cough, laughing sneezing, or jumping[625.6]	☐	☐	
Pain with urination	☐	☐	Painful intercourse (sex)[625.0]	☐	☐	
Painful Breasts	☐	☐	Abnormal Breast discharge	☐	☐	
Hot flashes[627.2]	☐	☐	OTHER			

Menstrual Profile:

Age of first period:_____.I am ☐ irregular-or-☐ regular, bleed for _____days, ☐ pass Clots[626.2], ☐ have PMS[625.4]

Any and all STDs?:

Last PAP date: Normal? *yes no*[795.0] Ever Abnormal? *yes no* Ever any LEEP/Cryo/Cone *yes no*

Last Mammogram date: Normal? *yes no* Ever Abnormal? *yes no* Ever any GYN Cancer *yes no*

Last colorectal screening date: *Last DEXA:*

Obstetrical History:

G	***T***	***P***	***A***	***L***

No	*Mon/ Yr*	*Sex*	*Wt*	*Wks Gestation*	*Hours in Labor*	*Del. Type*	*Anesthesia*	*Comments* Infertility, GDM, PIH, PTL, DVT/PTE, ABR, PPH[V13.7]
1.								
2.								
3.								
4.								
5.								

Medical History: ***(check if applicable)***

Obstetrical	*yes*	*no*	***Gynecology***	*yes*	*no*	***Comments***
Anemia	☐	☐	DES exposure	☐	☐	
Fetal Death[V23.2]	☐	☐	Incompetent Cervix	☐	☐	
Gestational Diabetes	☐	☐	Low weight baby	☐	☐	
Hypermesis	☐	☐	Hemorrhage	☐	☐	
Preterm labor/birth[V23.41]	☐	☐	Isoimmunization	☐	☐	
Post Partum Depression	☐	☐	**RH negative** ☐		☐	

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*Patient's Name:*_____
DOB:_____

Please tell us if you have or have had any of the following illnesses:

Check all that apply:	*yes* *no* (comment)		*yes* *no* (comment)
Accidents or Trauma	☐ ☐	Blood Transfusions	☐ ☐
Migraine Headaches	☐ ☐	Cancer of any kind	☐ ☐
Hyperthyroidism or Hypothyroidism	☐ ☐	Seizures/Convulsions/ Epilepsy	☐ ☐
Anemia/low platelets[V12.3]	☐ ☐	Bowel Trouble	☐ ☐
Kidney Diseases	☐ ☐	Liver or Gallbladder	☐ ☐
Diabetes	☐ ☐	GERD or Ulcers	☐ ☐
Venereal Disease	☐ ☐	Fractures	☐ ☐
Heart trouble/ Murmur	☐ ☐	Blood Clots in Legs	☐ ☐
High Blood Pressure	☐ ☐	HIV+ or AIDS	☐ ☐
Asthma	☐ ☐	Other:	
Rheumatic Fever	☐ ☐		
Lupus	☐ ☐		

Have you been hospitalized for any medical conditions? ☐ No If yes explain:_____

Have you had any operations or biopsies? ☐ No If yes explain:_____

Social History: Occupation: Abuse/Stress

Did you ever have sex when you really did not want to? Does anyone hit you? ☐ No Who:

Sleep:_____hrs/day ☐restful -or- ☐ poor Exercise_____ x/week gym walking other:

Are you on a special diet? ☐ No Which?

Smoke? *yes* *no* x_____ years Drink Alcohol?_____ x/week Use Street Drugs?_____ x/week

Have Sex:_____x/week Orientation: ☐ **Lesbian,** ☐ **Straight,** ☐ **Bisexual**, Birth Control Method?=_____

List all your current Meds: Over The Counter?, Vitamins, OCP: HRT:

List any drug or food Allergies:

Family Health History

	Name(s)	**Age(s)**	**High blood Pressure** V17.4	**Diabetes** V18.0	**Stroke** V17.1	**Heart Attack** V17.3	**Cancer** V16.9	**Alcoholism**
Mother								
Father								
Sisters								
Brothers								

BY MY SIGNATURE BELOW, I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE. IF I HAVE OMITTED ANY INFORMATION I hereby release Dr Moise Mamouzette and all his representatives and staff from liability for acts performed in good faith and without malice in connection with evaluating and treating me on the basis of the information I have provided or omitted

Signature of Patient _____ Date: _____

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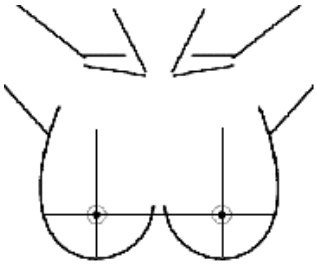


PE: GEN: BMI:

VS: BP T P ir-reg, R Weight Height

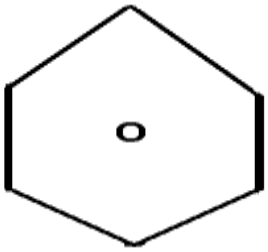
Neck: ☐ erythema ☐ adenopathy ☐ thyromegaly

Breasts: Skin ☐ Normal ☐ BSE TAUGHT

Tumors ☐ None ☐ multiple, diffuse, bilat, nontender, mobile, ≤5mm

D/C ☐ None

Nodes ☐ Normal

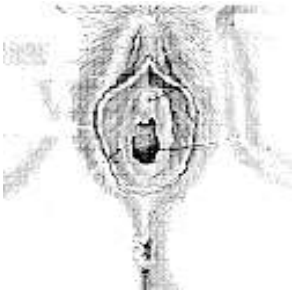


Back ☐ Normal

Abdomen: ☐ Normal Scars

Genitalia ☐ Normal

Vagina: ☐ Normal



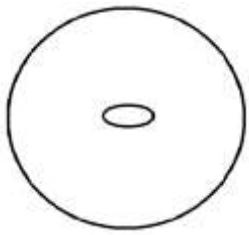
Cervix: ☐ Normal PAP ☐Yes ☐No

CT/NG ☐Yes ☐No

Uterus: ☐ Normal Bulky 621.2

Adnexa: ☐ Normal Mass 789.33, 4

Rectovaginal: ☐ Normal Guaiac: + / - 82270



Groin nodes ☐ Normal

Extremities: ☐ Normal Varicosities Edema

SKIN: ☐ Normal Vesicles Macules Papules

Blood _____
Urobili _____
Bili_____
Prot _____
Nitr _____
Ket _____
Glu_____
pH_____
SG _____
Leuk_____ 81002
Urine Culture
☐ Yes ☐ No 87088
UHCG: + / - 81025
Whiff: + / - 82120
Nitrizine: 83986
( )Acidic ( )Basic
Wet Mount 87210
_____
Ferning + / - Q0114

ASSESSMENT AND PLAN:

1

2

3

4

5

6

☐ US/TVS
☐ Colposcopy
☐ EMB
☐ Dx Surgery
☐ Rx Surgery
Consult: GI GU
Psy
F/U_____
☐REI W/U
☐URO W/U

COUNSELED RE: ☐ Smoking V65.42 ☐ Weight 278.00 ☐ Diet V65.3 ☐Exercise V65.41 ☐ FP & BCM V25.09 ☐ HIV V65.44 ☐ BSE V65.49

Counseled 9940X[ ] x15:00min Total Encounter [ ]min_ Signature; _____ Date:_____

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