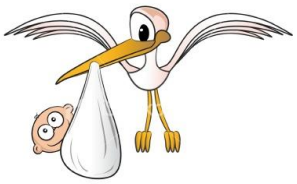
Date: __ __/ __ __/ __



OAHU OBGYN

Obstetrics and Gynecology

Kukui Plaza
50 S. Beretania St. Suite C-211-C
Honolulu, HI 96813
Phone: (808) 532-2020 **Fax**: 1 (808) 495-4236 **After Hours**: (808)524-2575

Initial Intake Form

Full Name: _____ Nickname_____ DOB: __ __/ __ __/ __ __
(MM/DD/YY)

Social Security Number: ____ ____ ____-____ ____-____ ____ ____ ____ Age: _____

Address: _____
Street City State Zip Code

Home #: (__ __ __) _____-_____ Cell #: (__ __ __) _____-_____ Work #: (__ __ __) _____-_____

Preferred Number to Leave a Message: (__ __ __) _____-_____ Email: _____@_____._____

Marital Status (circle one): Married Engaged Single Divorced Separated Widowed

Employer: _____ Occupation: _____

Employer's address: _____ _____
Street City State Zip Code

In Case of Emergency, Notify: _____ Relationship: _____

Phone number (day): (__ __ __) _____-_____ Phone number (night): (__ __ __) _____-_____

Primary Care Physician:_____ Referred by: _____

Preferred Language(s):_____ Preferred Pharmacy: _____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. INSURANCE AUTHORIZATION AND ASSIGNMENT & CONSENT FOR RELEASE OF INFORMATION

PLEASE READ AND SIGN

I hereby authorize Lynette W. Tsai, MD, Inc. to furnish information to insurance carriers concerning my illness and treatments. I also authorize Dr. Tsai to furnish necessary information regarding my health to other physicians participating in my care if they request it. If I do not desire to release such information, I will inform Dr. Tsai in writing. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand there is a $25-$50 fee for release of medical records. Unless extenuating circumstances apply, I agree to cancel or reschedule my appointment within 24 hours. I understand that I will be responsible for a $25.00 fee for any missed appointment. All fees are subject to change.

Signature: _____ Date: __ __/ __ __/ __ __ (MM/DD/YY)

Oahu OBGYN

Date: __ __/ __ __/ __

Name: _____

Reason for your visit: _____

Personal Medical History

Major Illnesses	**Yes**		**Yes**		**Yes**
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI disease		Hepatitis		Seizures	
GI Reflux disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting problem	
Cancer (Breast/Ovary/Uterus/Colon/Etc.):					
Other:					

Current Medications (Including supplements):

Drug Name	Dosage	Start Date

Allergies: drugs, latex, environment, food

Allergies:	Reaction:

Family History

☐ Adopted

*** Please indicate whether relationship associated is maternal or paternal** (Ex, Maternal Grandmother)*

Major Illnesses	**If yes, who?**		**If yes, who?**		**If yes, who?**
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI disease		Hepatitis		Seizures	
GI Reflux disease		Liver problem		Asthma	
Fibroids		Kidney infections/ stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting problem	
Family History of Cancer (Breast/Ovary/Uterus/Colon/Etc.):					
Other:					

Hospital & Surgical History

Year	Illness/Operation	Surgeon	Hospital

Date: __ __/ __ __/ __

Pregnancy History

	Number		Number
Total # of pregnancies		Living children	
Miscarriages		Vaginal deliveries	
Abortions		Cesarean sections	

Year	Duration of Pregnancy	Type of Delivery	Sex	Hours in Labor	Epidural Y or N	Weight	Hospital	Complications

Please describe any special pregnancy problems:

_____

Menstrual History

Age at first period: _____ Number of days of flow: _____ days
Are your periods regular (every 28-30 days)? ____ yes ____ no If not, how often? _____ days
Number of pads ___ or tampons ___ used on heaviest day?
Menstrual flow (please check one): ☐ very light ☐ light ☐ moderate ☐ heavy ☐ occasionally heavy ☐ variable
Are your periods painful (cramps)? ___ yes ___ no
How do you treat your pain? _____
When was the first day of your last menstrual period? __ __/ __ __/ __ __ (MM/DD/YY)
If menopausal, how old were you when it occurred? _____
Are you taking hormones? ___ yes ___ no
If so, what type and dosage? _____

Gynecological History

Have you ever been treated for: ☐ Herpes ☐ Chlamydia ☐ Gonorrhea
☐ Genital Warts ☐ Bacterial Vaginitis ☐ Trichomonas ☐ Syphilis

Have you had a Pap smear in the last 7 years? ☐ No ☐ Yes When? _____
Have you ever had an abnormal Pap smear? ☐ No ☐ Yes When?_____
What Abnormality?_____
If over age 35, have you had a mammogram? ☐ No ☐ Yes If so, when? __/__/__ where? _____
If over age 50, have you had a bone density scan done? ☐ No ☐ Yes If so, when? __/__/__ where? _____

Are you currently sexually active? ☐ No ☐ Yes ☐ Never
Did you begin sexual activity before 16 yo? ☐ No ☐ Yes If yes, Age started: ____
Have you had > 5 sexual partners in your lifetime? ☐ No ☐ Yes
Sexual Orientation: ☐ Heterosexual ☐ Lesbian ☐ Bi-Sexual

Are you currently using birth control? ☐ No ☐ Yes ☐ Trying to get pregnant
Current birth control method used: _____
Are you satisfied with it? ☐ No ☐ Yes

Past birth control methods:
☐ Condoms ☐ Birth control pills ☐ Withdrawal ☐ Tubal Ligation
☐ Diaphragm ☐ Patch ☐ Rhythm ☐ Vasectomy
☐ Vaginal Film ☐ Vaginal Ring ☐ IUD ☐ Essure

Have you ever tested positive for HIV? ☐ No ☐ Yes
Did your mother take the drug DES when she was pregnant with you? ☐ No ☐ Yes

Date: __ __/ __ __/ __

Name: _____ Date: __ __/ __ __/ __ __ (MM/DD/YY)

Social History

Personal Profile

Birth Place:_____ Ethnicity:_____ Religion:_____

School Completed: ☐ High School ☐ College ☐ Graduate Degree ☐ Other

Exercise: ☐ Yes ☐ No How often_____
Type:_____
Special Diet ☐ Yes ☐ No Type_____

Hobbies, Interests, Goals:_____

Habits

Smoking	☐ Yes	☐ No	Packs/day_____ Years_____ Quit when:_____
Alcohol	☐ Yes	☐ No	Drinks/day_____ Drinks/week_____ Quit when:_____
Drug Use	☐ Yes	☐ No	Type_____ Years_____ Quit when:_____
Caffeine	☐ Yes	☐ No	Cups per day_____ Cups per week_____
Street Drugs	☐ Yes	☐ No	If so, what did you use? _____

Do you use seatbelts?	☐ Yes	☐ No	Do you use sunscreen?	☐ Yes	☐ No
Do you own guns in your home?	☐ Yes	☐ No	If yes, is it in a secure location?	☐ Yes	☐ No

Personal Safety

☐ Yes	☐ No	Has anyone close to you ever threatened to hurt you?
☐ Yes	☐ No	Has anyone ever hit, kicked, choked or hurt you physically?
☐ Yes	☐ No	Has anyone, including you partner, every forced you to have sex?
☐ Yes	☐ No	Are you ever afraid of your partner?

Date: __ __/ __ __/ __

Review of Systems

Please check if you have any of the following symptoms:

1. Constitutional		Notes	7. Genitourinary (cont.)		Notes
Fever	☐		Abnormal bleeding	☐	
Chills	☐		Vaginal discharge/odor	☐	
Fatigue	☐		Vaginal itching/burning	☐	
Weight loss	☐		Pelvic pain	☐	
Weight gain	☐		Menstrual cramps	☐	
2. Eyes			Painful intercourse	☐	
Change in vision	☐		Genital lump	☐	
Double vision	☐		Fertility concerns	☐	
3. ENT/Mouth			Menopausal concerns	☐	
Ear aches	☐		**8. Musculoskeletal**		
Ringing in the ears	☐		Muscle weakness	☐	
Sinus problems	☐		Joint stiffness	☐	
Sore throat	☐		Joint pain	☐	
Mouth sores	☐		Joint swelling	☐	
Dry Mouth	☐		**9. Skin/Breast**		
4. Cardiovascular			Breast pain	☐	
Chest pain	☐		Nipple discharge	☐	
Difficulty breathing on exertion	☐		Breast lumps	☐	
Swelling of legs	☐		Rash	☐	
Palpitations	☐		Ulcers	☐	
Heart Murmurs	☐		**10. Psychiatric**		
5. Respiratory			Depression	☐	
Wheezing	☐		Mood swings	☐	
Spitting up blood	☐		Anxiety	☐	
Shortness of breath	☐		Suicidal thoughts	☐	
Cough	☐		Homicidal thoughts	☐	
6. Gastrointestinal			**11. Endocrine**		
Diarrhea	☐		Abnormal thirst	☐	
Constipation	☐		Hot flashes	☐	
Nausea/vomiting	☐		Tremors	☐	
Bloody stool	☐		Cold/heat intolerance	☐	
Abdominal pain	☐		**12. Hematologic**		
Indigestion	☐		Frequent bruising	☐	
Bloating	☐		Cuts do not stop bleeding	☐	
Liver problem/Hepatitis	☐		Enlarged lymph nodes	☐	
7. Genitourinary					
Blood in urine	☐				
Pain with urination	☐		**13. How tall are you?**		
Urgency	☐				
Urinary Frequency	☐				
Urinary Incontinence	☐				

Please bring the above to the attention of your Primary Care Physician if not addressed today.

Date: __ __/ __ __/ __

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I been provided an opportunity to review it.

I acknowledge that by adding or switching to QUEST insurance may result in termination of care with Lynette W. Tsai, M.D., Inc. I understand I will be held responsible for any outstanding balance accrued and establish OBGYN care with a new provider.

Print Name_____ Birthdate____/_____/_____

Signature_____ Date____/_____/_____