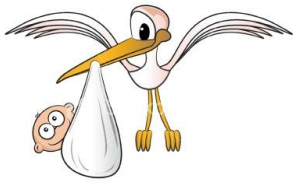

OAHU OBGYN

Obstetrics and Gynecology

Kukui Plaza: 50. S. Beretania St. Suite C-211C Honolulu, HI 96813 (F) 808-532-2027
Mehana Kapolei: 1020 Kakala St #903 Kapolei, HI 96707 (F) 808-674-8936

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 Apt# 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.e. MY DEDUCTIBLE).** 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 $50.00 fee for any missed appointment. All fees are subject to change.

Please note that if a letter is requested from Oahu OBGYN, that is NOT considered to be a medical necessity, there will be a $20.00 administrative fee. We will also require a minimum of 3 days' notice for this request.

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

Personal Medical History

Reason for visit:_____

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

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? ☐ Never ☐ No ☐ Yes

Did you begin sexual activity before 16 y/o? ☐ 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

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?

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.

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 Oahu OBGYN. 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**____/_____/_____

OAHU OB/GYN

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPPA, requires that our office has your consent prior to our healthcare professional discussing your personal health with your family members or significant others.

*Can our Providers discuss your healthcare with any of your family members? YES / NO (please ***circle***)

*Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

*What kind of health information do you authorize Oahu OB/GYN to disclose to the designated person(s)?

____ All – at my Provider's discretion	_____ Tests ordered	_____Test Results
____ Date of Treatment	_____ Diagnosis	_____ Treatment Options
____ Treatment Plan	_____Medical History	_____Other_____

This authorization will be in effect until such time you request its revision. You have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization.
You do not have to complete this authorization in order to receive treatment from Oahu OB/GYN.
Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

*_____ * ____/_____/_____
Signature Date

*_____ * _____/_____/_____
Print Name BIRTHDATE

* E-mail: _____@_____._____

OAHU OBGYN

(P) 808-532-2020 | **Elation EMR Fax: 1-808-495-4236**
LYNETTE TSAI, M.D., KATHY GADAINGAN, APRN, ERICA CADIZ-SALES, APRN, WIMONRAT FURSEY, APRN

COVID-19 SCREENING NOTICE

The safety of our employees is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the potential risk of exposure to our staff and patients we ask that you please respond to each of the following questions truthfully and to the best of your ability

BY ENTERING THIS WORKSITE, YOU ARE AFFIRMING AND REPRESENTING THAT:

1. In the past 4 weeks you have NOT tested positive for COVID-19, or you are NOT presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms.

2. You have NOT been tested for COVID-19 in the last 2 weeks or waiting to receive test results.

3. You are NOT currently experiencing, or have NOT experienced any of the following symptoms in the last 14 days:

☐ Cough
☐ Shortness of breath or difficulty breathing
☐ Fever of 100.4° F or higher
☐ Chills
☐ Muscle pain
☐ Sore throat
☐ New loss of taste or smell
☐ Nausea, diarrhea, vomiting

4 You have NOT, in the past 14 days, been in close contact to anyone who experienced any of the above symptoms or has experienced any of the above symptoms since your contact.

5 You have NOT, in the past 14 days, been in close contact to anyone who has tested positive for COVID-19.

6 You are NOT subject to any Hawaii state or county inter-island travel quarantine order.

_____

Name Signature Date