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OBSTETRICS | GYNECOLOGY | INFERTILITY | INCONTINENCE
www.especiallyforwomen.net

Consent for Purpose of Treatment, Payment or Health Care Operations

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

I understand that 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 health care operations. Especially for Women is not required to agree to the restrictions that I may request. However, if Especially for Women agrees to a restriction that I request, the restriction is binding on Especially for Women's practice. I have the right to revoke this Consent, in writing, at any time, except to the extent that Especially for Women's practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information is information related 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 the right to review Notice of Privacy Practices for Especially for Women prior to signing this document.

Notice of Privacy Practices for Especially for Women has been provided to me.

The Notice of Privacy Practices for Especially for Women's practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of Especially for Women's health care operations.

A summary of the Notice of Privacy Practices for Especially for Women is also posted in the waiting room.

This Notice of Privacy Practices for Especially for Women also describes my rights and the duties of Especially for Women's practice with respect to my protected health information.

Especially for Women reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for Especially for Women.

I may obtain a revised Notice of Privacy Practices for Especially For Women by contacting the office of Especially for Women at 1890 SW Health Parkway, Suite 205, Naples, FL 34109 or by calling (239) 592-1388.

Name of Patient (Please Print) Signature of Patient or Representative Date

Name of Representative (Please Print) Employee Initials



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NOTICE OF PRIVACY PRACTICES – REVISED APRIL 14, 2003

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 our office Privacy Officer at
1890 SW Health Parkway, Suite 205, Naples, FL 34109 or call (239) 592-1388.

WHO WILL FOLLOW THIS NOTICE:

This notice describes information about privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclosed health information about you and describes your rights and our obligations regarding the disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your plan about treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest or benefit to you.

Health-Related Products or Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (see office address at end of notice) that you do not wish to receive such communications, we will use every effort to not use or disclose your information for these purposes.

You may revoke your **Consent**, at any time by giving us a written notice. Your revocation will be effective when we receive it, but it will not apply to any uses or disclosures which occurred prior to that time.

If you do revoke your **Consent**, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operation, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS:

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security, and Intelligence: If you were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information about you to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies 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 a dispute, we may disclose health information about you to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring our spouse with you into the exam room during treatment or while your treatment is being discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any other purpose other than those identified in the previous sections without your specific, written **Authorization**. We must obtain your **Authorization** separate from and **Consent** we may have obtained from you. If you give us **Authorization** to use or disclose health information about you, you may revoke that **Authorization** in writing at any time. If you revoke your **Authorization**, but, we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different from the **Authorization** and **Consent** mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed **Consent** and a special written **Authorization** that complies with the law governing HIV or substance abuse.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you:

Right To Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the practice Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing and other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health care information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right To Amend: If you believe that health information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the practice Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect or copy
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request “an accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the practice Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also, have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

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. We will make all reasonable efforts to accommodate this request. For example, you may not wish us to contact you at work.

Right to a Paper Copy of This Notice: You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To receive a copy of this notice, contact the practice Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

We will post a summary of the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Security of the Department of Health and Human Services. To file a complaint with our office, contact the practice Privacy Officer. You will not be penalized for filing a complaint.

Thank you for taking the time to read this information.



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OBSTETRICS | GYNECOLOGY | INFERTILITY | INCONTINENCE

PATIENT HEALTH HISTORY QUESTIONNAIRE

Please complete all 3 pages

Name: _____ Date: _____

Primary Care Doctor _____ Pharmacy Used/Location _____

Doctor's Office Phone #: _____ Referred by: _____

Reason for Visit: _____

ALLERGIES: None

Medication or Substance	Reaction
-------------------------	----------

1. _____
2. _____
3. _____
4. _____

MEDICATIONS: None

Medication	Dosage	Frequency	Reason
------------	--------	-----------	--------

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY HISTORY: None:

Age	Heath Problem or cause of death
-----	---------------------------------

- | | |
|-----------------|-------|
| Father: | _____ |
| Mother: | _____ |
| Siblings: | _____ |
| | _____ |
| Children: | _____ |
| | _____ |
| | _____ |
| Uncles / Aunts: | _____ |
| | _____ |
| | _____ |
| Grandparents: | _____ |
| | _____ |
| | _____ |
| | _____ |

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

REPRODUCTIVE & MENSTRUAL HISTORY:

Total # of Pregnancies _____ # Miscarriages _____ # Terminations _____
 # of Full Term _____ # Ectopics _____ # Living children _____
 # Premature _____ # Multiple Births _____

Date of last menstrual period: _____ Flow Amount: _____ Method of birth control: _____
 Regularity: _____ Are you in Menopause: _____ On hormone replacement : _____
 Frequency: _____

GENERAL HEALTH SCREENINGS:

Date of last Pap smear: _____ Date of last Bone Density Scan: _____
 Date of last Colonoscopy: _____ Date of last Mammogram: _____

PAST GYNECOLOGIC HISTORY: (Do you have or have you ever had):

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal PAP Smear | <input type="checkbox"/> Dysplasia | <input type="checkbox"/> Menorrhagia (heavy bleeding) |
| <input type="checkbox"/> Amenorrhea (no menses) | <input type="checkbox"/> Dysfunctional Bleeding | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Anovulation (no ovulation) | <input type="checkbox"/> Ectopic pregnancy | <input type="checkbox"/> Ovarian cyst |
| <input type="checkbox"/> Bartholin's gland cyst | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pelvic adhesions/infections |
| <input type="checkbox"/> Candidiasis (chronic yeast) | <input type="checkbox"/> Fibroid uterus | <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> PMS/PMDD |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Polycystic ovaries (PCOS) |
| <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Herpes Simplex (HSV) | <input type="checkbox"/> Recurrent vaginitis |
| <input type="checkbox"/> Cold Knife Conization | <input type="checkbox"/> Human Papilloma Virus | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cryosurgery | <input type="checkbox"/> Blocked/Dilated Fallopian Tubes | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Cystocele (dropped bladder) | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Uterine polyps |
| <input type="checkbox"/> DES Exposure in utero | <input type="checkbox"/> Infertility | <input type="checkbox"/> Uterine prolapse |
| <input type="checkbox"/> Dyspareunia (painful sex) | <input type="checkbox"/> Irregular Periods | |
| <input type="checkbox"/> LEEP | | |

Comments: _____

PAST MEDICAL HISTORY: (Do you have or have you ever had):

- | | | |
|--|---|--|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cholesterol, elevated | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> GERD / Reflux |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Cancer – Type _____ | <input type="checkbox"/> Hepatitis (A, B, or C) |
| <input type="checkbox"/> Arthritis/RA | <input type="checkbox"/> Congestive Heart Disease | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD (Lung Disease) | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Incontinence (Stress, Urgency, Frequency) |
| <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> DVT (Venous embolism) | <input type="checkbox"/> Interstitial Cystitis |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Fibromyalgia | |

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

PAST MEDICAL HISTORY continued: (Do you have or have you ever had):

- | | | |
|---|--|--|
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Kidney Infection/stone | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Transient ischemic attack (TIA) |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Skin Cancer | |

Comments: _____

PAST SURGICAL / DIAGNOSTIC HISTORY: **None**

- | | | |
|--|--|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Knee surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> C/Section # _____ | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> D&C # _____ | <input type="checkbox"/> LASIK (eye correction) |
| <input type="checkbox"/> Breast augmentation | <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> Ovary Removal |
| <input type="checkbox"/> Breast reduction | <input type="checkbox"/> Endometrial ablation | <input type="checkbox"/> Pacemaker implant |
| <input type="checkbox"/> Breast lumpectomy | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Pelvic Floor Rehabilitation |
| <input type="checkbox"/> Breast mastectomy | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Shoulder surgery |
| <input type="checkbox"/> Bladder lift | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> CABG (coronary bypass) | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Cholecystectomy/Gallbladder | <input type="checkbox"/> Hysterectomy (abdominal) | <input type="checkbox"/> Tonsillectomy & Adenoids |
| <input type="checkbox"/> CMG | <input type="checkbox"/> Hysterectomy (vaginal) | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Hysterectomy-laparoscopic | |

Comments: _____

- | | Yes | No | If so, how much? |
|-------------------------------------|--------------------------|--------------------------|------------------|
| Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever smoked? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you drink ? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you smoke marijuana ? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you use recreational drugs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you perform monthly breast exam? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is your diet well balanced? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you use seat belts? | <input type="checkbox"/> | <input type="checkbox"/> | |



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NEW OBSTETRIC PATIENT HEALTH HISTORY QUESTIONNAIRE – FORM A/B

NAME: _____
 LAST FIRST MIDDLE
 HOSPITAL OF DELIVERY NCH – North Collier Hospital PRMC – Collier Hospital
 REFERRED BY _____
 PRIMARY PROVIDER/GROUP _____
 BIRTH DATE (MM/DD/YYYY) _____ AGE _____ RACE _____ MARITAL STATUS S M W D SEP
 OCCUPATION: HOMEMAKER OUTSIDE WORK Type of Work _____ STUDENT

ADDRESS: _____

 INSURANCE CARRIER/MEDICAID # _____

 EMERGENCY CONTACT _____
 PHONE _____
 EDUCATION (LAST GRADE OF COMPLETION) _____

TOTAL PREG	FULL TERM	PREMATURE	AB INDUCED	AB SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY: Date of last menstrual period: _____ Definite Approximate (Month Known) Unknown
 On Birth Control Pill at conception? Yes No
 Menses Monthly Yes No Frequency (# of Days between periods) _____ Duration _____ (# of days period lasts) Menarche (Age Period Began) _____

DATE MONTH YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR YES / NO	COMMENTS / COMPLICATIONS

PAST MEDICAL HISTORY: (Do you have or have you ever had):

	0 Neg + Pos	DETAIL POSITIVE REMARKS INCLUDE DATE(S) & TREATMENT
Diabetes		
Hypertension		
Heart Disease		
Auto Immune Disorder		
Kidney Disease		
Neurologic / Epilepsy		
Psychiatric		
Hepatitis / Liver Disease		
Varicosities / Phlebitis		
Thyroid Dysfunction		
Trauma / Domestic Violence		
History of Blood Transfusion		
D (rh) Sensitized		
Pulmonary (TB, Asthma)		
Allergies (Drugs)		
Breast		
Gyn Surgery		

Operations / Hospitalizations		
Anesthetic Complications		
Uterine Anomaly		
Infertility		
Relevant Family History		
Other		

	AMT/DAY PRE-PREG	AMT/DAY PREG.	# YEARS USE
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Street Drugs	_____	_____	_____

Additional Comments: _____

GENETIC SCREENING / TERATOLOGY COUNSELING: Select all that apply:

Includes Patient, Baby's Father, or Anyone in Either Family With:

- | | |
|---|---|
| <input type="checkbox"/> Patient's Age > 35 Years | <input type="checkbox"/> Mental Retardation / Autism
If yes, was person tested for Fragile X? _____ |
| <input type="checkbox"/> Thalassemia (Italian, Greek, Mediterranean or Asian Background) MCV < 80 | <input type="checkbox"/> Other Inherited Genetic or Chromosomal Disorder |
| <input type="checkbox"/> Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly) | <input type="checkbox"/> Maternal Metabolic Disorder (eg Insulin-Dependent Diabetes, PKU) |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Patient or Baby's Father had a Child with Birth Defects not Listed Above |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Recurrent Pregnancy Loss or a Stillbirth |
| <input type="checkbox"/> Tay Sachs (eg, Jewish, Cajun, French Canadian) | <input type="checkbox"/> Medications / Street Drugs / Alcohol Since Last Menstrual Period
If Yes, Agent (s): _____ |
| <input type="checkbox"/> Sickle Cell Disease or Trait (African) | <input type="checkbox"/> Any Other |
| <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Muscular Dystrophy | |
| <input type="checkbox"/> Cystic Fibrosis | |
| <input type="checkbox"/> Huntington Chorea | |

Comments / Counseling :

INFECTION HISTORY:

	Yes	No		Yes	No
High Risk Hepatitis B / Immunized Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Rash or Viral Illness since Last Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/>
Live with Someone with TB or Exposed to TB	<input type="checkbox"/>	<input type="checkbox"/>	History of STD, GC, Chlamydia, HPV, Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Patient or Partner has History of Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to Cat Litter	<input type="checkbox"/>	<input type="checkbox"/>	Warts	<input type="checkbox"/>	<input type="checkbox"/>
Other					

Comments: _____

INTERVIEWER'S SIGNATURE: _____



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NOTICE TO OBSTETRIC PATIENT
(See Section 766.316, Florida Statutes)

I have been furnished information by Especially for Women (Joseph Gauta, MD, Jody Alexander, MD, Emily Collette Clements, DO, Amanda Schultz, PA-C) prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Especially for women and each of the above providers is a participant in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, P.O. Box 14567, Tallahassee, Florida 32317-4567, (800) 398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

Dated this _____ day of _____, 20 _____.

Signature: _____

Print Name: _____

Attest: _____ Date: _____

(Staff/Provider)



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CONSENT FOR HIV TESTING

I, _____ understand that Quest Diagnostics Inc.
(Name of Patient)

is being requested by _____ to perform a test for
(Name of Provider)

antibodies to Human Immunodeficiency Virus (HIV) on my blood. The provider or staff has counseled me as to the meaning of the test and I have given consent for the procedure. I understand that Quest Diagnostics Inc. will send the results of my test back to the provider's office and I will receive them from the provider.

Patient Signature: _____ Date: _____

CONSENT FOR RELEASE OF TESTING INFORMATION

I authorize Joseph Gauta, MD, Jody Alexander, MD, Emily Collette Clements, DO, Amanda Schultz, PC-C to furnish to any payors, information that may aid in payment of my account. I agree that no one will be held liable for supplying this testing information or these medical records to my payors.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

(For office use)



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ULTRASOUND VISIT INFORMATION

The ultrasound equipment used at Especially for Women is 3-D but we may not be able to get a 3-D picture of the baby at one of your early appointments. As your pregnancy progresses, we will try to give you a great picture !

Normally at about 16-20 weeks we can determine the sex of your baby — so please inform us whether or not you want to know the gender.

If you would like to record the ultrasound, **please bring a blank VHS tape** (our equipment does not record on CDs).

You do not need a full bladder for a vaginal or abdominal ultrasound.

If you are scheduled for a saline-infusion sonohysterography (an ultrasound with fluid infused into the uterus) take Advil or Tylenol prior to the scan.

Due to space limitations we request that you bring yourself and **not more than two guests** for the ultrasound visit. A child must be accompanied by an adult other than yourself during the visit.

Thank you for cooperation and assistance.