REVIEW OF SYSTEMS AND MEDICAL HISTORY FORM

Patient's Name:____ D.O.B. ______________________________

Reason for Visit:_______________________________________ Email:_______________________________________

In order for your Physician to complete your exam, it is extremely important to complete this form in its entirety, including ALL PAST MEDICAL HISTORY. **ANY SECTIONS LEFT BLANK WILL RESULT IN A DELAY OF YOUR VISIT.**

CONSTITUTIONAL SYMPTOMS

Good general health lately………………………… ☐No ☐Yes
Recent weight change……………………………… ☐No ☐Yes
Fever……………………………………………… ☐No ☐Yes
Fatigue…………………………………………… ☐No ☐Yes
Exercise regularly………………………………… ☐No ☐Yes
Eat a balanced diet………………………………… ☐No ☐Yes

EYES

Eye disease or injury……………………………… ☐No ☐Yes
Wear glasses/contact lenses……………………… ☐No ☐Yes
Blurred or double vision…………………………… ☐No ☐Yes
Glaucoma………………………………………… ☐No ☐Yes

EARS/NOSE/THROAT

Hearing loss or ringing…………………………… ☐No ☐Yes
Earaches or drainage……………………………… ☐No ☐Yes
Chronic sinus problem or rhinitis………………… ☐No ☐Yes
Nose bleeds……………………………………… ☐No ☐Yes
Mouth sores……………………………………… ☐No ☐Yes
Bleeding gums…………………………………… ☐No ☐Yes
Sore throat or voice change……………………… ☐No ☐Yes

CARDIOVASCULAR

Heart trouble……………………………………… ☐No ☐Yes
Chest pain or angina pectoris……………………… ☐No ☐Yes
Palpitation………………………………………… ☐No ☐Yes
Shortness of breath with walking………………… ☐No ☐Yes
Swelling of feet, ankles or hands………………… ☐No ☐Yes
Murmur…………………………………………… ☐No ☐Yes
Mitral valve prolapse……………………………… ☐No ☐Yes

RESPIRATORY

Chronic or frequent coughs……………………… ☐No ☐Yes
Spitting up blood………………………………… ☐No ☐Yes
Shortness of breath……………………………… ☐No ☐Yes
Asthma or wheezing……………………………… ☐No ☐Yes

GASTROINTESTINAL

Loss of appetite…………………………………… ☐No ☐Yes
Change in bowel movements……………………… ☐No ☐Yes
Nausea or vomiting………………………………… ☐No ☐Yes
Frequent diarrhea………………………………… ☐No ☐Yes
Constipation……………………………………… ☐No ☐Yes
Rectal bleeding or blood in stool………………… ☐No ☐Yes
Abdominal pain…………………………………… ☐No ☐Yes
Peptic ulcer (stomach or duodenal)……………… ☐No ☐Yes
Reflux……………………………………………… ☐No ☐Yes

MUSCULOSKELETAL

Joint pain…………………………………………… ☐No ☐Yes
Joint stiffness or swelling………………………… ☐No ☐Yes
Weakness of muscles or joints…………………… ☐No ☐Yes
Muscle pain or cramps…………………………… ☐No ☐Yes
Back pain…………………………………………… ☐No ☐Yes
Cold extremities…………………………………… ☐No ☐Yes
Difficulty in walking……………………………… ☐No ☐Yes
Sports injury……………………………………… ☐No ☐Yes

INTEGUMENTARY (SKIN BREAST)

Rash or itching…………………………………… ☐No ☐Yes
Change in skin color……………………………… ☐No ☐Yes
Change in hair or nails…………………………… ☐No ☐Yes
Varicose Veins……………………………………… ☐No ☐Yes
Breast pain………………………………………… ☐No ☐Yes
Breast lump………………………………………… ☐No ☐Yes
Breast discharge…………………………………… ☐No ☐Yes
Changing mole……………………………………… ☐No ☐Yes

NEUROLOGICAL

Frequent or recurring headaches………………… ☐No ☐Yes
Light headed or dizzy……………………………… ☐No ☐Yes
Convulsions or seizures…………………………… ☐No ☐Yes
Numbness or tingling sensations………………… ☐No ☐Yes
Tremors……………………………………………… ☐No ☐Yes
Paralysis…………………………………………… ☐No ☐Yes
Stroke……………………………………………… ☐No ☐Yes
Head injury………………………………………… ☐No ☐Yes

PSYCHIATRIC

Memory loss or confusion………………………… ☐No ☐Yes
Nervousness……………………………………… ☐No ☐Yes
Depression………………………………………… ☐No ☐Yes
Insomnia…………………………………………… ☐No ☐Yes

ENDOCRINE

Glandular or hormone problem…………………… ☐No ☐Yes
Thyroid disease…………………………………… ☐No ☐Yes
Diabetes…………………………………………… ☐No ☐Yes
Insulin or Non-Insulin (circle one)
Excessive thirst or urination……………………… ☐No ☐Yes
Heat or cold intolerance…………………………… ☐No ☐Yes
Skin becoming dryer……………………………… ☐No ☐Yes
Change in hat or glove size………………………… ☐No ☐Yes

GENITOURINARY

Frequent urination……………………………………… ☐No ☐Yes
Burning or painful urination………………………… ☐No ☐Yes
Blood in urine……………………………………………… ☐No ☐Yes
Incontinence or dribbling…………………………… ☐No ☐Yes
Kidney stones……………………………………………… ☐No ☐Yes
Sexual difficulty………………………………………… ☐No ☐Yes
Pain with periods………………………………………… ☐No ☐Yes
Use douche…………………………………………………… ☐No ☐Yes
Irregular periods………………………………………… ☐No ☐Yes
Vaginal discharge………………………………………… ☐No ☐Yes
History of vaginal/pelvic infection………………… ☐No ☐Yes

OB/GYN HISTORY

Age at first intercourse:_____________________________
Date of last PAP smear:_____________________________
Date of last Mammogram:___________________________
Type of Birth Control currently using:_________________

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts……………………………… ☐No ☐Yes
Bleeding or bruising tendency…………………… ☐No ☐Yes
Anemia……………………………………………………… ☐No ☐Yes
Phlebitis…………………………………………………… ☐No ☐Yes
Past transfusion………………………………………… ☐No ☐Yes
Enlarged glands………………………………………… ☐No ☐Yes

MENSTRUATION HISTORY

Age at the onset of menstruation: ____________________
Date of **LAST** Menstrual Period: ______________________
PLEASE NOTE: WE CANNOT DO A PAP IF YOU ARE ON YOUR PERIOD
Number of days menstruation lasts: _________________
# of Pads/Tampons used:___________________________

ALLERGIES-Please list all known allergies:
____
____

LIST ALL PREGNANCIES INCLUDING; DATES, WEIGHTS, DELIVERY TYPE and any problems.
*****(Please include miscarriages, terminations and pre-term)*****
____
____
____

PAST MEDICAL HISTORY Please list **ALL PREVIOUS** medical history including surgeries, injuries, diseases, hospitalizations AS WELL AS Conditions such as High Blood Pressure and High Cholesterol:_______________ _______________________
____
____

MEDICATIONS (Please list **ALL** medications currently taking **including** Vitamins and Supplements)__________________
____
____

PATIENT SOCIAL HISTORY

Marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
Use of alcohol: ☐Never ☐Number per week:____
Use of tobacco: ☐ Never ☐Previously Quit-Date Quit:______________________ ☐Current-packs per day:________
Use of drugs: ☐Never ☐Type/Frequency:____
History of: ☐Sexual assault:________________________________ ☐Domestic violence:______________________

FAMILY MEDICAL HISTORY:

	Age:	Diseases:	If deceased, cause of death
Father:			
Mother:			
Siblings:			
Children:			
Other blood relatives:			

I have filled out the form completely and understand any sections left blank will result in a delay of my visit:

Patient Signature:____ Date:____________________________

PATIENT CONTRACT WITH CONSENT TO TREAT

CONSENT TO TREAT

By signing this form I understand that I am consenting that ObGyn Specialists of Fort Lauderdale, it's Physicians, Nurse Practitioners, Medical Assistants, Technicians or Medical Students (when applicable) can provide and perform medical care, tests, procedures or a medically indicated examination including but not limited to a pelvic exam as agreed upon in the best interest of my health. _______ **Patient Initials**

TREATMENT OF STAFF

We take great pride in assisting our patients and providing exceptional patient care. If you or anyone representing you act in an abusive manner to a staff member or a Physician you may be asked to leave and/or discharged from the practice. We have a Zero Tolerance policy for the mistreatment of our staff and Physicians so please be mindful of your behavior. **_______Patient Initials**

CO-PAYMENTS AND EXISTING ACCOUNT BALANCES

Co-Payments are due at the time of service. *No Exceptions*. If you have an existing account balance at the time of your visit, you are expected to pay the balance at your visit or set up an auto-payment plan to make timely payments. See the Front Desk for more information on the auto-payment plan. **________Patient Initials**

FORMS AND LETTER REQUESTS

All forms & letter requests may take up to 10 business days to complete so please be mindful of that timeframe when submitting a request. ALL patient information must be filled out on forms and all letter requests must include ALL information needed for the letter. If incorrect information is provided, there will be a $10 charge for each additional corrected form or letter. **_______Patient Initials**

APPOINTMENT CANCELLATIONS and LATE ARRIVALS FOR APPOINTMENTS

There will be a $25 charge for ANY appointment, (i.e. LAB, Ultrasound, Dr visit, Nurse visit etc.) not cancelled with a 48-hour notice. We have an appointment reminder system that notifies you via email, phone and text so if you must cancel, please use the system. You are considered late if you arrive more than 15 minutes past your scheduled time. We will do our best to see you but you may be asked to wait or reschedule. **_______Patient Initials**

BY SIGNING THIS CONTRACT, I, AS THE PATIENT, AGREE TO BE AN ACTIVE PARTICIPANT IN MY CARE AND THAT I UNDERSTAND THAT I MAY BE DISCHARGED FROM THE CARE OF OBGYN SPECIALISTS OF FORT LAUDERDALE AT THE DISCRETION OF THE PHYSICIANS IF ANY OF THE ABOVE TERMS ARE NOT FOLLOWED.

I FULLY UNDERSTAND AND ACCEPT THE TERMS STATED ABOVE:

Print Patient Name: ____ Patient D.O.B.________________

Patient Signature: _______________________________________ Today's Date: ________________

Healow Portal Website Registration

Once Pts are Web Enabled in the office they will receive a Welcome email titled:
"Portal login information from your doctor's office"

****Important-PLEASE check Junk or Spam folder**

1. Login Credentials will be In the Welcome email. It will show:
   Login URL: https://health.healow.com/ForWomenOnlyFTL (This is the portal website)
   User ID: JaneDoe1970 (Example Only)
   Password: 5CpY3Z7n (Example-this is a temp password you will change later-CASE SENSITIVE)

2. Click the link above and enter the credentials above to log in

3. Validate your identity with Date of Birth or PH # (it has to match what we have in the system)

4. Next reset your Password and set up Security questions

5. Next- Acknowledge EClinical Works Consent by clicking Next

6. Last-Acknowledge our Practice consent by **checking** the box and clicking **Agree**

Healow Portal App

***At the bottom of the Welcome email or any email from the portal there is a section that says "Let's Connect Via our Healow App-this has our unique "Practice Code" listed**

Step 1. Download Healow App from App Store

Step 2. Enter our unique "Practice Code" to find us: **CHAJAD**

Step 3. Login with User ID & Password (Use Temp info **ONLY IF** you haven't registered on the site yet

Step 4. Agree to Terms