PATIENT INFORMATION FORM

DR. VICENTE SILVA

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Birthdate: ____/____/____

Phone: (____) _____ - _____ Please Indicate: Cell ☐ Home ☐

Driver's License #: _____ Social Security #: _____-____-_____

Martial Status: Married ☐ Single ☐ Divorced ☐ Widow ☐

Do You Have a Primary Care Physician?: Yes ☐ No ☐ If So Name: _____

Primary Care Physician Phone: (____) _____ - _____

Primary Language Spoken at Home: _____

**Person Responsible for Bill: _____

_____

Your Occupation: _____ Employer Name: _____

Employer Address: _____

Business Phone: (____) _____ - _____ Please Indicate: Cell ☐ Business ☐

In Case of Emergency Notify: _____ Relationship: _____

Phone: (____) _____ - _____ Please Indicate: Cell ☐ Home ☐

Spouse Name: _____ Spouse Social Security #: _____-____-_____

Spouse Employer Name/Address: _____

Business Phone: (____) _____ - _____ Please Indicate: Cell ☐ Business ☐

INSURANCE INFORMATION

1st Insurance Company Name: _____

Address: _____ Contact/Policy/or ID#: _____

Group Name: _____ Please Indicate: Group ☐ Private ☐

Name of Subscriber: _____ Birthdate: ____/____/____

2nd Insurance Company Name: _____

Address: _____ Contact/Policy/or ID#: _____

Group Name: _____ Please Indicate: Group ☐ Private ☐

Name of Subscriber: _____ Birthdate: ____/____/____

PHYSICIANS RELEASE AND ASSIGNMENT

I HEREBY AUTHORIZE PAYMENT TO DR. VICENTE SILVA, M.D. OF BENEFITS DUE TO ME FROM MY INSURANCE COMPANY OTHERWISE PAYABLE TO ME. SHOULD I FORGO MY INSURANCE AND PAY FOR SERVICES OR USE OUT OF NETWORK BENEFITS I UNDERSTAND THAT MY PHYSICIAN WILL NOT SUBMIT CLAIMS TO THE INSURANCE COMPANY NOW OR IN THE FUTURE. THEREFORE, I WILL BE SOLEY RESPONSIBLE FOR ALL SERVICES. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER(S). A COPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIES ANY INFORMATION NEEDED FOR OR RELATED MEDICARE CLAIM. I REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

Patient Signature: _____ **Date:** _____

PATIENT VISIT INFORMATION

Name: _____ **DOB:** _____ **Date** _____

☐ **I am here today for a Well woman visit**

☐ **I am here with a specific issue I need evaluated, which is** _____

☐ **I am here for both reason**

Update Medical History Since Last Visit

Medical Conditions

_____

_____

_____

Self: ☐ **Thrombo-emboli (Blood clots)** ☐ **Diabetes** ☐ **Heart Disease**

Current Medications

(Name and dosage)

_____

_____

_____

Family Cancer History

Type of Cancer	Family Member

(Type and family member)

Allergies: ☐**None** ☐ Seasonal ☐IV contrast ☐Penicillin ☐Sulfa ☐Surgical tape

☐Iodine ☐Latex ☐**Other**

Other: _____

First day of last period: _____ ☐**MENOPAUSE**

Last Mammogram: _____ ☐ **N/A**

When was your last visit to general/primary doctor? _____

LAB : ☐ **QUEST** ☐ **LAB CORP**

Signature _____

Vicente Silva, MD

Vicente Silva, M.D., LLC
FINANCIAL POLICY

Thank you for choosing { LLC name }as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

WE ACCEPT: CASH, CHECK, and credit cards

INSURANCE: We will bill your insurance company for your visit as a courtesy to you. Due to difficulty of obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider of your insurance plan.

HMO/REFERRALS: It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visits. It is the patients' responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of the bill.

RETURNED CHECKS: Any check returned for any reason will be subject to any bank fees charged to us along with 5% of the face value of the check or $25 administrative fee (whichever is greater).

COLLECTIONS : Should your account become a collection problem, the patient/debtor assumes all costs of collection including but not limited to collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

NON-COVERED SERVICES: You will be responsible for payment of services "not covered" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy . I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient/Responsible Party Signature:_____ Date:_____

*Print Patient Name:*_____

Revised 10/29/03 MC

VICENTE SILVA, M.D., LLC
OBSTETRICS AND GYNECOLOGY

700 N. Hiatus Road
Suite 211
Pembroke Pines, FL 33026

Tel: (954) 437-3700
Fax: (954) 437-1204

"Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law."

.....

Patient Signature

.....

Date

Revised 08/04

Notice of Privacy Acknowledgement

Vicente Silva, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print) _____ Date _____

Signature _____

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

Notice of Privacy Practices
Vicente Silva, MD, LLC

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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health Information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose 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 Health Information so that we or others 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 your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose 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 use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose 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 Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. 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 any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for electronic copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with 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. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

700 N. Hiatus Road, Suite 211
Pembroke Pines, FL. 33025
Office: : (954) 437-8700
Fax: (954) 437-8704

English Notice of Nondiscrimination

This medical practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This medical practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This medical practice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the office administrator.

If you believe that this medical practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the office administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish Notice of Nondiscrimination / Aviso español de no discriminación

Esta práctica médica cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Esta práctica médica no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Esta práctica médica:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con el administrador de la oficina.

Si considera que esta práctica médica no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: el administrador de la oficina. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el administrador de la oficina está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web
http://www.hhs.gov/ocr/office/file/index.html.

COVID-19 Patient Health Survey

For Your Safety and that of others please answer the following questions: Thank you for your cooperation.

- Have you traveled by air or sea to an affected geographic area that is known to be associated with COVID-19?

  Yes_____ NO_____

  If your response is yes, where and when did you travel?

  _____

  _____

  _____

- Have you recently come in close contact with a laboratory-confirmed COVID-19 patient?

  YES_____ NO_____

  If your response is yes, when did you encounter this patient?

  _____

  _____

  _____

- Are you experiencing a fever, chills, cough, sore throat, runny nose, loss of taste or smell and /or having trouble breathing?

  YES_____ NO_____

  If your response is yes, when did these symptoms start?

  _____

  _____

  _____

Patient Signature: _____ Date: _____

VICENTE A. SILVA, M.D., F.A.C.O.G.
DIPLOMATE AMERICAN BOARD OF OBSTECTRICS & GYNECOLOGY

700 N. HIATUS ROAD, SUITE 211
PEMBROKE PINES, FL 33026
(954) 437-3700
FAX: (954) 437-1204

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I consent to medically indicated physical/gynecological examinations which may include, but may not be limited to the following:

A female gynecological exam including a pelvic and/or breast exam.
An ultrasound exam which may include a probe placed in the vagina.
A medically indicated rectal exam.
A testing procedure which may include a probe placed into the vagina and/or rectum during a pelvic support treatment procedure.

This examination will be performed by any provider from Vicente Silva, M.D., LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

_____

Date _____

VICENTE SILVA, M.D., LLC

Meaningful Use Form

Patient's Full Legal Name: _____ Date of Birth: _____

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please Check ONE in EACH CATEGORY that applies)

RACE		ETHNICITY	PREFERRED LANGUAGE	
☐ White	☐ More Than One	☐ Hispanic or Latino	☐ English	☐ Hindi
☐ Black or African American	☐ Native Hawaiian	☐ Not Hispanic or Latino	☐ Spanish	☐ Vietnamese
☐ Asian	☐ Other Pacific Islander	☐ Refused to Report/Unreported	☐ Urdu	
☐ American Indian or Alaskan Native	☐ Undefined	☐ Undefined	☐ Refused to Report/Unreported	
☐ Refused to Report/Unreported			☐ Other _____	

Patient's Email Address: _____

HOW DID YOU HEAR ABOUT US? (Please Check the ONE that applies)

☐Family/Friend	☐ Online Yellow Pages	☐ Employer Website	☐ Internet Search	☐ Billboard
☐Hospital	☐ Newspaper	☐ Mailer	☐ Radio	☐ Doctor
☐Seminar-Special Event	☐ Sports Team Support	☐ TV	☐ Worker's Comp	☐ Other: _____
☐Existing Patient	☐ Self Referral			☐ Other _____

_____ _____

Signature of Patient, Guardian or Legal Representative Date

5/14

700 North Hiatus Road, Suite 211 Pembroke Pines, FL 33025
Phone:(954) 437-3700 Fax: (954) 437-1204

Vicente Silva, M.D., LLC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Dr. Vicente Silva to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Relationship to Patient: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

VICENTE SILVA, M.D., LLC
700 North Hiatus Road., Suite 211
Pembroke Pines, FL 33026

PHARMACY INFORMATION

(Please print)

Pharmacy name: _____

Address: _____

Street City State Zip code

Phone number: _____

☐PRFERRED LOCATION

Pharmacy name: _____

Address: _____

Street City State Zip code

Phone number: _____

Patient Name: _____

Last First M

Date of Birth (MM/DD/YYYY): _____

Patient Signature: _____

VICENTE A. SILVA, M.D., F
700 North Hiatus Road, Suite 211
Pembroke Pines, FL 33026

(TIENT IDENTIFICATION

Patient's name:

ID#:

GYNECOLOGY HEALTH HISTORY Date:

Age | Race | Education | Occupation | Referring physician

Reason for seeing doctor:

Past Medical History

	Patient	Family
1 Headaches or a nervous disorder	☐	
2 A thyroid problem	☐	
3. A heart condition or high blood pressure	☐	☐
4. A lung disorder	☐	☐
5 Breast problems	☐	☐
6. Jaundice, hepatitis, or other liver disorders	☐	☐
7 Stomach, bowel or gallbladder problems	☐	
8 Kidney or bladder problems	☐	
9 Female or sexual problems	☐	
10 Allergies or drug sensitivities	☐	
11 Anemia or blood disorders	☐	☐
12 A blood transfusion	☐	
13 Diabetes	☐	☐
14. Cancer	☐	☐
15. Birth defects or inherited diseases	☐	☐
16. Other medical problems	☐	☐
17 Presently taking medications	☐	

Check and detail all findings below Use reference numbers

18. Hospitalizations (Check box ☐ if more than four)

Mo/yr	Illness or operation	Complications No	Complications Yes
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐

19 Obstetrical History

Please list the number of: Premature births | Miscarriages | Abortions | Times pregnant | Living children

No	Birth mo/yr	Weight at birth	Baby's sex	Weeks preg.	Type of delivery	Complications No	Complications Yes
1	/	lb oz				☐	☐
2	/	lb oz				☐	☐
3	/	lb oz				☐	☐
4	/	lb oz				☐	☐
5	/	lb oz				☐	☐

LAST MAMMOGRAM -

20 Menstrual History

LMP _____ ☐ Abnormal bleeding

Onset _____ ☐ Pain

Cycle ___ ___ ☐ Leukorrhea

Length _____

Amount per heaviest day

22. Family Planning

	me?	mo?
Oral contraceptive	☐	☐
IUD	☐	☐
Diaphragm	☐	☐
Other	☐	☐

Sterilization ☐ Male ☐ Female

Interruptus ☐ Yes ☐ No

Duration

LAST PAP =

ABNORMAL - NEVER

DATE -

RSLT -

STD

MSO

PID

21. Sexual History

	Yes	No
Sexually active	☐	☐
Frequency ___ times per ___		
Satisfac	☐	☐
Dyspareunia	☐	☐

23. Marital History

☐ Married ☐ Single

No. of years _____ ☐ Sep. ☐ Divorced

No. of times _____ ☐ Widowed

SMOKE -

REC. DRUGS -

ETOH -

Signature: Vicente A. Silva, M.D.