Kathleen E. Goodman, MD, LLC
Gynecology
5975 Sunset Drive, Suite 701
South Miami, Florida 33143

COVID-19 QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ DOB: _____

1. Have you experienced any of the following symptoms in the last 14 days?
   - Fever — Yes No
   - Cough — Yes No
   - Shortness of breath or difficulty breathing — Yes No
   - Sore Throat — Yes No
   - Chills or body aches — Yes No
   - Loss of smell or taste — Yes No
   - Headache — Yes No
   - Muscle aches or pain — Yes No
   - Fatigue — Yes No
   - Congestion or runny nose — Yes No
   - Nausea, vomiting or diarrhea — Yes No

2. Have you been in close contact with someone who has been diagnosed with COVID-19 in the last 14 days? Yes No

3. Have you previously had COVID-19? Yes No
   If yes, when? _____

4. Have you previously been tested for COVID-19? Yes No
   If yes, when? _____
   What was the result? Negative Positive

5. Have you traveled in the last 14 days? Yes No

6. Have you received the COVID-19 vaccine? Yes No
   If yes, when?
   1st Dose _____ 2nd Dose _____

   Vaccine Name _____

I hereby certify that the above statements are true and correct and understand that a false statement may disqualify me from further services.

_____
Patient Signature

Kathleen E. Goodman, MD, LLC

Gynecology

Patient Information

Please print clearly and answer all questions

Date _____
Fecha

Patient Name _____
Nombre del Paciente

Home Address _____
Direccion de Hogar

City _____ State _____ Zip Code _____
Ciudad Estado Codigo Postal

Date of Birth _____ Age _____
Fecha de Nacimiento Edad

Occupation _____
Ocupacion

Employer _____
Empleador

Work Address _____
Direccion

City _____ State _____ Zip Code _____
Ciudad Estado Codigo Postal

Spouse's Name _____
Nombre de Esposo(a)

Spouse's Employer _____
Empleador

Emergency Contact _____
Contacto de Emergencia

Referred By _____
Referido Por

Primary Language Spoken _____
Idioma Preferido

Home Phone _____
Telefono del Hogar

Work Phone _____
Telefono del Trabajo

Cell Phone _____
Cellular

E-Mail _____

Social Security # _____
Numero de Seguro Social

Marital Status _____
Estado Civil

Drivers License # _____
Numero de Licensia de Conducir

D.O.B. _____ Spouse's S.S. # _____
Fecha de Nacimiento Numero del Seguro Social

Spouse's Work Phone _____
Telefono del Trabajo

Phone Number _____
Telefono

If you are here for a well woman exam, please check this box ☐
Si esta aqui para un examen rutinario marque esta casetilla ☐

INSURANCE INFORMATION

Name of Primary Insurance _____
Nombre del Seguro

Address _____
Direccion

Group Number _____
Numero de Grupo

Name of Subscriber _____
Nombre del Asegurado

Subscriber's Employer _____
Empleador

Phone Number _____
Telefono

City _____ State _____ Zip Code _____
Ciudad Estado Codigo Postal

Policy or I.D. Number _____
Numero de Poliza

D.O.B. _____ Relation to Patient _____
Fecha de Nacimiento Relacion al Paciente

Work Phone _____
Telefono

RELEASE OF INFORMATION / ENTREGA DE INFORMACION
I authorize the release of any medical information necessary to process a claim.
Yo autorizo la entrega de cualquier informacion médica necesaria para poder procesar un reclamo.

ASSIGNMENT OF BENEFITS / RENDIMIENTO DE BENEFICIOS
I authorize payment of Medical benefits to myself or the name provider for professional services rendered.
Yo autorizo pago de servicios/beneficios médico a mi persona o al proveedor profesional de los servicios.

Signed: _____ **Date:** _____
Firma **asegurado / subscriber or patient** **Fecha**

#101KG 01/04 RN

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Patient History Form

Patient Name _____ Date of Birth _____ Age _____

Occupation _____ Ethnic Origin _____ Sex _____

Marital Status (Please check one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced Primary Language _____

ALLERGIES	
Medicinal	Other

CURRENT MEDICATIONS	

Last Menstrual Period _____ Age at first menstrual Period _____

Are/were your periods usually (Please check one): ☐ Irregular ☐ Regular Have Periods Stopped? ☐ Yes ☐ No

Difficulty with Periods? ☐ Yes ☐ No

Specify: _____

Number of Pregnancies _____ # Live Births _____ # Abortions _____ # Miscarriages _____ # Stillborn _____

Describe pregnancy complications, if any _____

Are you currently sexually active (Please check one): ☐ Yes ☐ No Method of Contraception: _____

MAJOR ILLNESSES	Yes	No	MAJOR ILLNESSES	Yes	No
Asthma	☐	☐	Cancer	☐	☐
Pneumonia	☐	☐	Ulcers	☐	☐
Chronic Lung Disease	☐	☐	Depression/anxiety	☐	☐
Kidney Infections/stones	☐	☐	Anemia/Blood Transfusions	☐	☐
Tuberculosis	☐	☐	Seizures/convulsions/epilepsy	☐	☐
Venereal Disease	☐	☐	Bowel Trouble	☐	☐
Heart Trouble/murmur	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis/ joint pain	☐	☐
High Blood Pressure	☐	☐	Fracture(s)	☐	☐
Stroke	☐	☐	Hepatitis/Yellow jaundice	☐	☐
Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐
INJURIES:					

OPERATIONS / HOSPITALIZATIONS			
Surgeris	Date	Hospitalization	Date

Patient Signature _____ Physician Signature _____

Date: _____ Reviewed: _____ _____ _____

PATIENT HISTORY FORM-continued

SOCIAL HISTORY

	Yes	No	Quit		
Tobacco Use	☐	☐	☐	Packs Per Day	Years
Alcohol	☐	☐	☐	Drinks Per Day	Drinks Per Week
Drug Use	☐	☐	☐	Specify	How often
Other Drugs or Medications	☐	☐	☐		
Regular Exercise	☐	☐	☐		
Monthly Self Breast Exams	☐	☐	☐		
Yearly Mammograms	☐	☐	☐		
Colon Cancer Screening	☐	☐	☐		

Please indicate whether immediate relatives (parents, siblings, grandparents, aunts/uncles, cousins, or children) have or died from any of the following:

FAMILY HISTORY

Illness	N/A	Relative	Illness	N/A	Relative
Breast Cancer			High Blood Pressure		
Ovarian Cancer			Heart Disease		
Cervical Cancer			Stroke		
Uterine Cancer			Diabetes		
Colon Cancer			Osteoporosis		
Obesity			Alzheimer's Disease		
Other			Mental Illness		

Review of Systems: Do you have or have you had any problems related to the following systems? Please check Yes or No.
Please explain any Yes answers in the space provided

Constitutional Symptoms	**Yes**	**No**
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Eyes		
Blurred Vision	☐	☐
Double Vision	☐	☐
Vision Changes	☐	☐
Ear/Nose/Throat/Mouth		
Ear Infection	☐	☐
Sore Throat	☐	☐
Sinus Problems	☐	☐
Cardiovascular		
Painful Breathing	☐	☐
Chest Pain	☐	☐
Swelling of Legs	☐	☐
Palpitations of Heart	☐	☐
Respiratory		
Wheezing	☐	☐
Frequent Cough	☐	☐
Shortness of Breath	☐	☐
Hematologic/Lymphatic		
Swollen Glands	☐	☐
Blood Clotting Problems	☐	☐
Frequent Bruising	☐	☐
Endocrine		
Dry Skin	☐	☐
Abnormal Thirst	☐	☐
Hot Fashes	☐	☐

Skin/Breast	**Yes**	**No**
Skin Rash	☐	☐
Pain in Breast	☐	☐
Discharge	☐	☐
Boils	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Neck Pain	☐	☐
Muscle Weakness	☐	☐
Other_____		
Genitourinary		
Blood in Urine	☐	☐
Painful Urination	☐	☐
Urinary Frequency	☐	☐
Urine Retention	☐	☐
Painful Intercourse	☐	☐
Urinary Incontinence	☐	☐
Other_____		
Gastrointestinal		
Diarrhea, Frequent	☐	☐
Bloody Stool	☐	☐
Abdominal Pain	☐	☐
Constipation	☐	☐
Neurological		
Tremors	☐	☐
Dizzy Spells	☐	☐
Numbness	☐	☐

Other _____

_____

Kathleen E. Goodman, M.D., LLC
5975 Sunset Drive, Suite 701
South Miami, Florida 33143
Phone: 305-740-9957 Fax: 305-740-8024

Gynecology

PHONE MESSAGE CONSENT

From time to time in caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak to directly, we would like to leave a message if possible.

We will attempt, as a courtesy, to leave a reminder message regarding an upcoming appointment.

In order to protect your privacy, we have developed a policy on leaving messages.

- We will not discuss any medical or financial information with anyone except the patient or legal guardian.
- We will not leave any medical or financial information on an answering machine and we will not leave any medical or financial information on a voice mail system UNLESS we have your written permission to leave a message for you. Please read the information below and consider carefully whom you want to have access to your medical and/or financial information, such as test results.

Please fill out only ONE of the following sections below to make your preference known.

A. I DO CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, give permission to Kathleen Goodman, MD, and her staff to leave phone messages regarding my medical care and/or financial status.

Initial for each one you wish to have your messages left

_____ My home phone answering machine phone # _____
_____ My work phone voice mail phone # _____
_____ My cell phone voice mail phone # _____
_____ My e-mail address _____
_____ My spouse (name) _____ Phone # _____
_____ Other (name) _____ Phone # _____

Signature: _____ Date: _____

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care and/or financial status be left on an answering machine, voice mail or with others.

Signature: _____ Date: _____

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Our Financial Policy

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

COPAYMENT, DEDUCTIBLE AND/OR CO-INSURANCE IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS, DISCOVER.

AUTHORIZATION * ASSIGNMENT * GUARANTEES

1. GUARANTEE OF PAYMENT
For and in consideration of service rendered or to be rendered to this patient by Kathleen E. Goodman, MD, I/we hereby guarantee payment of any and all bills rendered for such patient which are not covered or allowed by insurance, together with all collection costs, understanding that all bills are payable and become due upon presentation.

2. ASSIGNMENT OF INSURANCE BENEFIT
I/We authorize payment directly to Kathleen E. Goodman, MD, of all benefit arising from insurance through which patient is insured and which are otherwise payable to me.

3. PERSONAL PROPERTY
It is understood that Kathleen E. Goodman, MD, LLC, is not responsible for personal property, valuables, and appliances retained by the patient.

4. AUTHORIZATION OF RELEASE OF INFORMATION
I/We authorize release of medical and other patient information as required for collection of benefits, insurance or third party source of payment in connection with the condition, illness or injury of the patient.

5. CONSENT OF TREATMENT
I/We the undersigned hereby authorize the physician assigned, as provided by law, to furnish medical or surgical treatment to the patient, as he/she considers necessary and proper in the treatment of the patient for the purpose of correcting his/her physical condition.

6. $25.00-NO SHOW/24 HOUR CANCELLATION FEE
I/We understand there will be a $25.00 No Show fee charged to the patient if an appointment cancellation is not received within 24 hours of the scheduled appointment.

7. I/We certify that I/we fully understand the nature of the above.

_____ Date

_____ Witness

_____ Signature of Patient

_____ Signature of Insured

If patient is a minor or incapable of signing:

_____ Guardian

_____ Relationship

Notice of Privacy Acknowledgement

Kathleen E. Goodman, 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: _____

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE of Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE of Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE of Diagnosis	RELATIVES on your FATHER'S SIDE	AGE of Diagnosis
X Y ☐ N	*EXAMPLE: BREAST CANCER*	42			Aunt, Colon	61	Grandmother	53
Y N	BREAST CANCER							
Y N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
Y N	UTERINE/ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
Y N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

Y N Are you of Ashkenazi Jewish descent?

Y N Are you concerned about your personal and/or family history of cancer?

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- Breast cancer diagnosed at age 50 or younger
- Ovarian cancer at any age
- Two primary occurrences of breast cancer
- Male breast cancer
- Triple Negative Breast Cancer
- Pancreatic cancer with a breast or ovarian cancer
- Ashkenazi Jewish ancestry with an HBOC-associated cancer*

*Lynch Syndrome*** *(see cancer list below)*

- Colorectal cancer under age 50
- Endometrial/uterine cancer under age 50
- MSI High histology*** before age 60
- Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- Two or more Lynch syndrome cancers** at any age
- YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

*Lynch Syndrome*** *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor-infiltrating lymphocytes, crohn's-like lymphocytic reaction, histology or medullary growth pattern.*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date:_____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient referred to Hereditary Cancer Genetic Testing? YES / NO / PENDING / ACCEPTED / DECLINED

Follow up appointment scheduled? YES / NO Date of NEXT Appointment: _____