Virginia Obstetrics & Gynecology, P.C.

DEMOGRAPHICS UPDATE

Even if none of your information below has changed, please fill out the first section below for insurance and billing purposes. Thank you.

Name of Patient: _____ Date of Birth _____

Current Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____ Alt #: _____

Email: _____ Marital status: S M W Sep. D Other

Employer: _____ Occupation: _____ Work #: _____

Name of preferred Pharmacy: _____ located on _____

UPDATED INSURANCE INFORMATION

If none of your insurance information has changed, there is no need to complete this information. If you insurance has changed, please be prepared to give the receptionist your new insurance card.

Primary Insurance Co.: _____ Effective Date: _____

Address (back of card): _____ Phone: _____

Policy Holder's Name: _____ Date of Birth: _____

Relation to Patient: _____ Member ID: _____ Group #: _____

Secondary Insurance Co.: _____ Effective Date: _____

Address (back of card): _____ Phone: _____

Policy Holder's Name: _____ Date of Birth: _____

Relation to Patient: _____ Member ID: _____ Group #: _____

Privacy Notice Acknowledgement

At Virginia Obstetrics & Gynecology we follow a strict HIPAA regulation. We will never sell or give your information to any other persons without your request. By signing this form you acknowledge that you have reviewed, understand and comply with Virginia Obstetrics & Gynecology's Patient Privacy Acknowledgement regulated by the Health Insurance Portability and Accountability Act.

_____ _____

Name of Patient (printed) Date of Signature

_____ _____

Signature of Individual or Personal Representative Relationship IF OTHER THAN PATIENT

See reverse for HIPAA and PIH Act

Please be advised. We cannot give information to anyone without your written consent.

I give permission to Virginia Obstetrics and Gynecology, P.C. to speak with the person(s) listed below regarding my medical care.

1. _____ _____ _____

2. _____ _____ _____

Authorized person(s) **Relationship to Patient** **Phone Number**

I authorize Virginia Obstetrics and Gynecology, P.C. to leave a voicemail message at the following number. Messages may at times include health information, including appointment reminders, test results, and instructions. I understand that with my signature I am authorizing the release of verbal communication by Virginia Obstetrics and Gynecology, P.C. to these voicemail numbers.

HOME_____ CELL_____ WORK_____

SIGNATURE_____DATE_____

VIRGINIA OBSTETRICS AND GYNECOLOGY, P.C.
MEDICAL HISTORY UPDATE

Welcome back to our Practice. We would like to update any relevant changes to your health history that may have occurred since your last annual or comprehensive visit. Please take a few minutes to complete this form and give the form to your physician.

Name_____Today's Date_____

Primary Care Physician_____Marital Status: (Circle One) S M Sep D W SSP

Current Occupation_____Last Menstrual Period_____

REASON FOR TODAY'S VISIT/CHIEF COMPLAINT: (Please circle all that apply)

1. Annual examination
2. Difficulty getting pregnant
3. Problems with periods
4. Menopausal symptoms
5. Contraceptive advice
6. Planning pregnancy
7. Problems with intercourse
8. Abnormal bleeding
9. Unusual discharge
10. Other_____
11. Breast mass
12. Pain
13. Difficult PMS
14. No problems

Your current method of birth control is:_____.

Sterilization_____ No current need_____

Have you been pregnant since your last visit? YES____ NO____

Are you sexually active at present? YES____ NO____

MEDICAL HISTORY

Have you had any changes in your medical history since your last yearly checkup? _____ NO _____YES

Please Specify:_____

_____

FAMILY HISTORY

Has anyone in your family developed any new diseases or died within the last year? _____NO _____YES

Please Specify:_____

_____

SURGICAL PROCEDURES PERFORMED SINCE YOUR LAST ANNUAL EXAMINATION

Month/year	Procedure	Month/year	Procedure

YOUR OTHER HEALTH CARE DOCTORS ARE: (please list all but **not** your dentist)

_____

_____

YOUR CURRENT MEDICATIONS ARE:(please list all including vitamins, herbs, birth control)

_____ _____

_____ _____

_____ _____

PLEASE TURN PAGE OVER

Patient Name_____ **Today's Date**_____

ALLERGIES: (Food, Medications, Latex): ❑ No known allergies

_____

_____

REVIEW OF HEALTH SYSTEMS: Are you having problems with any of the following:

CONSTITUTIONAL:

Weight gain or loss-more than 10 lbs.	NO YES
Marked fatigue	NO YES
Unexplained night fever/sweats	NO YES
Migraine headaches	NO YES

EARS/NOSE/MOUTH/THROAT:

Hearing loss	NO YES
Chronic sinus problems	NO YES
Nose bleeds	NO YES

CARDIOVASCULAR:

Heart trouble	NO YES
Chest pain or angina pectoris	NO YES
Palpitations	NO YES
Swelling of feet or ankles	NO YES

RESPIRATORY:

Chronic or frequent cough	NO YES
Spitting up blood	NO YES
Shortness of breath	NO YES
Asthma	NO YES

GASTROINTESTINAL:

Difficulty swallowing	NO YES
Frequent diarrhea or constipation	NO YES
Stomach ulcers	NO YES

PSYCHIATRIC:

Depression	NO YES
Anxiety disorder	NO YES

MUSCULOSKELETAL:

Joint stiffness or swelling	NO YES
Weakness in muscles or joints	NO YES
Back pain	NO YES

NEUROLOGICAL:

Lightheadedness or dizziness	NO YES
Convulsions or seizures	NO YES
Numbness/tingling in extremities	NO YES
Tremors	NO YES
Paralysis/stroke	NO YES
Head injury/concussion	NO YES

HEMATOLOGIC/LYMPHATIC:

Bruising tendency	NO YES
Anemia	NO YES
Phlebitis	NO YES
Transfusion in last year	NO YES
Persistent enlarged glands	NO YES

INTEGUMENTARY (skin, breast):

Rash or itching	NO YES
Change in skin color/hair/nails	NO YES
Breast pain/lump/discharge	NO YES

PLEASE INDICATE YOUR CURRENT USE AND/OR STATUS OF THE FOLLOWING (TYPE & FREQUENCY)

HABITS: Cigarettes: Never Smoked____ Quit (year)____ Current # cigarettes/day_____

Alcohol: None_____ # drinks/week____ More than 2 drinks/day_____

Caffeine: _____cups per day.

Have you used illegal drugs in the last year? YES____ NO_____

Do you exercise? YES____ NO____ If yes, amount and type_____

Seatbelt use: Never_____ Occasionally____ Always_____

Calcium servings in diet per day:_____; Supplements per day_____mg.

Are you being physically, sexually or emotionally abused? YES_____ NO_____

Last full physical with internist or family practitioner: Year_____

Last tetanus shot (this is good for 10 years): Month/Year_____.

Have you had any of the following screening tests since your last visit:

Colonoscopy: Month/Year_____
DEXA Scan Month/Year_____
Mammogram: Month/Year_____

Do you perform monthly self breast examinations: YES____ NO_____

Ambry Genetics

Hereditary Cancer Questionnaire
(to be completed by patients)

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Instructions: This is a screening tool to help your healthcare provider determine if you would benefit from hereditary cancer genetic testing. Your healthcare provider will review this form looking for any risk factors for a hereditary cancer syndrome such as similar types of cancer running in the family, cancers diagnosed at young ages, or multiple cancer diagnoses in the same person.

DOES CANCER RUN IN YOUR FAMILY? CHECK THOSE THAT APPLY.

Please fill this form out to the best of your ability. Please only consider family members related to you **by blood**, such as your parents, grandparents, children, brothers, sisters, aunts, uncles, and cousins. If you share only one parent with a brother or sister, **please indicate that.**

	TYPE OF CANCER	YOURSELF/PARENTS/ BROTHERS/ SISTERS/CHILDREN	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (MOTHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (FATHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)
☑	EXAMPLE: Colorectal Cancer	Me	42			Aunt Uncle	46 55
☐	BREAST CANCER (in women or men)						
☐	OVARIAN CANCER (peritoneal/ fallopian tube)						
☐	UTERINE (ENDOMETRIAL) CANCER						
☐	COLORECTAL CANCER						
☐	PANCREATIC CANCER						
☐	KIDNEY (RENAL) CANCER						
☐	OTHER CANCER Type: _____						
☐	OTHER CANCER Type: _____						
☐	OTHER CANCER Type: _____						
☐	MORE THAN 10 COLORECTAL POLYPS (indicate how many)						

☐ My family's heritage is Ashkenazi Jewish (an ethnic background that may have a higher likelihood of hereditary cancer)

☐ I, or someone in my family, have had genetic testing for a hereditary cancer syndrome.
(Please describe and provide a copy of result if possible)

_____

_____

Possible Indications for Genetic Testing and Potential Testing Options*
(to be completed by healthcare provider)

WEIGHING THE OPTIONS:

- **Single Syndrome Testing**: These tests are targeted, analyzing one gene or syndrome at a time, and are often chosen if the patient/family is highly suspicious for one gene/syndrome and/or desires the lowest possible VUS rate.
- **High Risk Panel**: These tests simultaneously analyze multiple well-described genes with published management guidelines, and are often chosen if the patient/family is suspicious for multiple syndromes and/or only wants to be tested for genes with published management guidelines.
- **Comprehensive Panel**: These tests are more comprehensive and provide the greatest chance of identifying a mutation. They can be tumor-specific or general. Since there are more genes on these tests, the VUS rates are higher and some genes do not have published management guidelines.

PATIENT'S PERSONAL & FAMILY HISTORY	SINGLE SYNDROME TESTS	HIGH RISK PANELS	COMPREHENSIVE PANELS
Hereditary Breast Cancer			
☐ Early onset breast cancer (≤45, ≤35 for *TP53*)	*BRCA1/BRCA2, TP53*	BRCAplus	BreastNext, CancerNext
☐ Multiple primary cancers in one person (*e.g.* two primary breast cancers or breast and ovarian cancer)	*BRCA1/BRCA2*		
☐ Breast cancer in an Ashkenazi Jewish individual, triple negative breast cancer ≤60, or breast cancer in a man			
☐ Multiple close family members with breast and/or other cancers**			
Hereditary Gynecologic Cancer			
☐ Ovarian, fallopian tube, or primary peritoneal cancer at any age	*BRCA1/BRCA2*, Lynch syndrome^	GYNplus	OvaNext, CancerNext
☐ Uterine cancer <50 or with abnormal MSI/IHC	Lynch syndrome^		
☐ Multiple close family members with ovarian or uterine, and other cancers**			
☐ Multiple primary cancers in one person (*e.g.* uterine and breast or colorectal cancer)			
Hereditary Colorectal Cancer			
☐ >10 colorectal polyps in an individual	*APC, MUTYH*		ColoNext, CancerNext
☐ Colorectal cancer <50 or with abnormal MSI/IHC	Lynch syndrome,^ *APC, MUTYH*		
☐ Multiple close family members with colon, uterine, ovarian, and/or stomach cancer**			
☐ Multiple primary cancers in one person (*e.g.* two primary colorectal cancers or colorectal and uterine cancer)			
Hereditary Pancreatic Cancer			
☐ Pancreatic cancer ≤60	Lynch syndrome,^ *BRCA1/BRCA2, PALB2, CDKN2A*		PancNext, CancerNext
☐ Multiple primary cancers in one person (*e.g.* pancreatic and melanoma)			
☐ Multiple close family members with pancreatic and/or other cancers**			
Hereditary Kidney Cancer			
☐ Kidney cancer ≤45	*VHL*		RenalNext, CancerNext-*Expanded*
☐ Multiple primary kidney cancers			
☐ Multiple close family members with kidney or other cancers**			
Hereditary PGL/PCC			
☐ Pheochromocytoma or paraganglioma at any age	*SDHx,^^ RET*		PGLNext, CancerNext-*Expanded*
Other Hereditary Cancers			
☐ Multiple types of tumors in one person or in a family, which are suspicious for more than one syndrome			CancerNext, CancerNext-*Expanded*

*This list of testing indications is not comprehensive and the testing options are suggestions. There are other situations not listed where genetic testing may be appropriate and other genes and tests available at ambrygen.com.

**On the same side of the family

^Lynch syndrome is caused by mutations in the *MLH1, MSH2, MSH6, PMS2*, and *EPCAM* genes

^^SDHx includes *SDHAF2, SDHB, SDHC*, and *SDHD*