VIRGINIA
OBSTETRICS
& GYNECOLOGY P.C
Jack P. Ayoub, MD

Welcome to our practice!

Thank you for choosing Virginia Obstetrics and Gynecology. We are very excited to have you with us!

We provide both obstetric and gynecological services, while specializing in preventative healthcare for women. Our emphasis is to provide patient centered care while individualizing treatment, in a trusting and friendly environment.

Our services include:
- Prenatal Care
- Intrapartum and post-partum care
- Management of high risk obstetrics
- Well-women care
- Problem oriented care

Our mission is not only to meet, but exceed the expectations of every single woman we care for and provide complete women's healthcare in a familiar friendly atmosphere.

Should you have any questions about our practice, services, or policies, please do not hesitate to call our office at (703) 858-5599 or visit our website at myvaobgyn.com.

Again, welcome and thank you for choosing us for your obstetric and gynecological needs.

Sincerely,

Jack P. Ayoub, M.D.

VIRGINIA OBSTETRICS & GYNECOLOGY, P.C.

44035 Riverside Parkway, Suite 435, Leesburg, VA 20176 Phone (703) 858-5599 Fax (703) 858-5699

PATIENT INFORMATION SHEET

Please Print

PERSONAL INFORMATION: Date_____

Patient's Name_____ Date of Birth_____ SSN_____
First MII Last

Address_____
Street City State Zip

Marital Status: S M Sep W D Home Phone_____ Cell Phone_____ Email_____

Employer_____ Occupation_____

Employer's Address_____ Work Phone_____

Spouse's Name_____ Work Phone_____

Emergency Contact_____ Relation to Patient_____ Phone_____

Referred by_____

INSURANCE INFORMATION:

Primary Insurance Co._____ Effective Date_____

Address_____ Phone_____

Policyholder's Name_____ Relation to Patient_____

Member ID #_____ Group #_____ Policyholder Date of Birth_____

Secondary Insurance Co._____ Effective Date_____

Address_____ Phone_____

Policyholder's Name_____ Relation to Patient_____

Member ID #_____ Group #_____ Policyholder Date of Birth_____

PERSON RESPONSIBLE FOR PAYMENT OR INSURANCE POLICYHOLDER (IF OTHER THAN PATIENT):

Legal Name_____ Relation to Patient_____
First MI Last

Address_____ Phone_____
Street City State Zip

Date of Birth_____ Sex: M F Marital Status: S M Sep W D

Employer's Name_____ Occupation_____

Employer's Address_____ Work Phone_____

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by Virginia Obstetrics & Gynecology, P.C. (the Practice). For those insurance plans for which the Practice accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me, including attorney fees if necessary. I authorize payment directly to the Practice for services for which the Practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

_____ _____

Signature of Patient or Parent/Legal Guardian Date

(Rev. 6/09)

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 & GYNECOLOGY, P.C.
CONFIDENTIAL PATIENT HISTORY

Welcome to our practice. The information on this form is intended to help the physician with your diagnosis and treatment. Please complete both sides of the form as fully as possible.

Name_____ Date_____

Primary Care Physician_____ Age_____ Birth Date_____

Marital Status: S M Sep W D SSP (same sex partner)

FAMILY HISTORY:

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or PGM- Maternal or Paternal), Aunt (A), Uncle (U):

No	Yes	Who		No	Yes	Who		No	Yes	Who	
❑	❑	_____	Diabetes	❑	❑	_____	High blood pressure	❑	❑	_____	Sickle cell disease
❑	❑	_____	Heart attack	❑	❑	_____	Stroke	❑	❑	_____	Birth defects/hereditary disease
❑	❑	_____	Cancer	❑	❑	_____	Blood clots (leg / lung)	❑	❑	_____	Osteoporosis
❑	❑	_____	Tuberculosis	❑	❑	_____	Thyroid disease	❑	❑	_____	Other_____

MEDICAL HISTORY:

Do you have, or have you ever had, any of the following:

No	Yes	Now		No	Yes	Now		No	Yes	Now	
❑	❑	❑	Sickle cell trait or disease	❑	❑	❑	Diabetes	❑	❑	❑	Kidney problem
❑	❑	❑	Heart disease	❑	❑	❑	Thyroid problem	❑	❑	❑	Recurrent bladder infection (>3 per year)
❑	❑	❑	Heart murmur	❑	❑	❑	Severe depression	❑	❑	❑	IBS
❑	❑	❑	Do you take antibiotics for dental work?	❑	❑	❑	Psychiatric problems	❑	❑	❑	GERD (reflux)
				❑	❑	❑	Numbness or tingling of extremities	❑	❑	❑	Colitis
❑	❑	❑	High blood pressure					❑	❑	❑	Liver disease/jaundice
❑	❑	❑	Varicose veins/phlebitis	❑	❑	❑	Epilepsy/seizures	❑	❑	❑	Hepatitis
❑	❑	❑	Blood clots (legs/ lungs)	❑	❑	❑	Stroke	❑	❑	❑	Mononucleosis
❑	❑	❑	Bleeding disorder	❑	❑	❑	Frequent headaches	❑	❑	❑	Asthma
❑	❑	❑	High cholesterol,	❑	❑	❑	Migraine headaches	❑	❑	❑	Gall bladder problem
❑	❑	❑	Positive tuberculosis test (PPD)	❑	❑	❑	Rubella infection or immunization (German measles)	❑	❑	❑	Any other illness (please list)
❑	❑	❑	HIV exposure								
❑	❑	❑	Cancer								
❑	❑	❑	Breast disease	❑	❑	❑	Chicken pox or immunization				

_____

_____

Date of last tetanus shot (month/year)_____

MEDICATIONS

List all medications you are using by name and dosage (include vitamins, calcium and herbs)

_____

_____

_____

_____

_____

_____

ALLERGIES

❑ No known allergies to medications

Allergies to medications: Please list name of drug and reaction:

_____

_____

Are you allergic to:

Copper	❑ Yes	❑ No
Rubber/latex	❑ Yes	❑ No
Iodine or shellfish	❑ Yes	❑ No

SURGICAL/HOSPITALIZATION HISTORY

Please list the date and type of surgery or reason for hospitalization:

Date	Type	Date	Type

MENSTRUAL HISTORY

Age period started_____ Date of last period_____

Periods come every _____ days and last for _____days. Periods are ❑ regular ❑ irregular ❑ light ❑ moderate ❑ heavy.

Do you have cramps with your period? ❑ No ❑ Yes If yes, what do you do for the discomfort_____

Do you bleed between periods? ❑ No ❑ Yes Do you ever use tampons? ❑ No ❑ Yes

GYN HISTORY

Date of last Pap smear_____ Date of last mammogram_____ Date of last DEXA Scan_____

No	Yes	Now	
❑	❑	❑	Vaginal discharge/infection
❑	❑	❑	Unusual vaginal bleeding
❑	❑	❑	DES exposure (did your mother take DES?)
❑	❑	❑	STD (sexually transmitted disease): ❑ syphilis ❑ gonorrhea ❑ trichomonas ❑ chlamydia ❑ herpes ❑ genital warts ❑ HIV

No	Yes	Now	
❑	❑	❑	Abnormalities of the uterus
❑	❑	❑	Tumors/cysts of ovaries
❑	❑	❑	Pain/bleeding with intercourse
❑	❑	❑	Abnormal Pap smear - describe_____
❑	❑	❑	Cervical lesions/biopsy/cryotherapy/Letz cone
❑	❑	❑	Premenstrual symptoms (mood changes, water retention, headaches, etc.)

(PLEASE TURN PAGE OVER)

Patient Name_____Today's Date_____

PREGNANCY HISTORY

Age of first pregnancy_____ ❑ Never been pregnant Have you ever had difficulty becoming pregnant? ❑ No ❑ Yes ❑ N/A

List number of: Pregnancies_____ Living children_____ Abortions_____ Miscarriages_____

Date of Pregnancies (date of delivery or termination)	Type of Delivery (Vaginal/C-section/VBAC/Termination/Miscarriage)	Sex

CONTRACEPTION

Total number of sexual partners in your lifetime_____

Age of first intercourse_____ Are you sexually active at present? ❑ No ❑ Yes Do you currently have a female partner? ❑ No ❑ Yes

If you have ever used birth control, please list all methods used in the past:

Birth control method	Date(s) of use	Any problems with this method (yes/no)

Present method_____ Used since_____ Any problems (yes/no)_____

SOCIAL/PERSONAL HISTORY

Highest year of school completed: 7 8 9 10 11 12 13 14 15 16 17 >17 Degree_____City/Country of Birth_____

Occupation_____Employer_____

Present weight is: ❑ Satisfactory ❑ Unsatisfactory Present weight is: ❑ About the same as a year ago ❑ More ❑ Less

Caffeine: Average #cups coffee/day _____ tea_____ caffeinated soda_____

Calcium: ❑ No ❑ Yes # servings/day (milk, cottage cheese, ice cream, yogurt)_____

Tobacco use: ❑ Never ❑ Quit (when)_____ ❑ Currently smoke _____packs/day for how many years_____

Marijuana use: ❑ No ❑ Yes Other street drugs: ❑ No ❑ Yes

What?_____

Do you feel you have a problem? ❑ No ❑ Yes

Alcohol: # drinks per week (beer, wine, liquor) _____ Do you feel you have a drinking problem? ❑ No ❑ Yes

How many drinks does it take to feel an effect?_____ Has anyone ever told you that you drink too much? ❑ No ❑ Yes

Have you ever been in treatment for alcohol problems? ❑ No ❑ Yes

What do you do for exercise?

Type/Frequency:_____ Have you been exposed to toxic substances? ❑ No ❑ Yes If so, what_____

Have you ever been physically, sexually, or emotionally abused? ❑ No ❑ Yes

Do you perform monthly breast self exams (BSE)? ❑ No ❑ Yes Do you use seat belts ❑ No ❑ Yes

Are you interested in HIV (AIDS) testing? ❑ No ❑ Yes

Sex: what questions do you have?_____

What concerns do you have to discuss with your health provider?_____

REVIEW OF SYSTEMS

Have you experienced any of the following within the last year? Please indicate NO, YES or NOW below.

No	Yes	Now	
			CONSTITUTIONAL
❑	❑	❑	Weight gain/loss > 10lbs.
❑	❑	❑	Marked fatigue
❑	❑	❑	Unexplained night fever/sweats
❑	❑	❑	Migraine headaches
			EARS/NOSE/MOUTH/THROAT
❑	❑	❑	Hearing loss
❑	❑	❑	Chronic sinus problems
❑	❑	❑	Nose bleeds
			CARDIOVASCULAR
❑	❑	❑	Heart trouble
❑	❑	❑	Chest pain/angina pectoris
❑	❑	❑	Palpitations
❑	❑	❑	Swelling of feet or ankles
			HEMATOLOGIC/LYMPHATIC
❑	❑	❑	Bruising tendency/bleeding disorder
❑	❑	❑	Anemia
❑	❑	❑	Varicose veins, blood clots, phlebitis
❑	❑	❑	Blood transfusion in last year
❑	❑	❑	Persistent enlarged glands
			GASTROINTESTINAL
❑	❑	❑	Difficulty swallowing
❑	❑	❑	Frequent diarrhea/constipation
❑	❑	❑	Stomach ulcers

No Yes Now

PSYCHIATRIC

❑ ❑ ❑ Depression

❑ ❑ ❑ Anxiety disorder

MUSCULOSKELETAL

❑ ❑ ❑ Joint stiffness/swelling

❑ ❑ ❑ Weakness in muscles or joints

❑ ❑ ❑ Back pain

NEUROLOGICAL

❑ ❑ ❑ Lightheadedness or dizziness

❑ ❑ ❑ Numbness or tingling of extremities

❑ ❑ ❑ Tremors

❑ ❑ ❑ Stroke/paralysis

❑ ❑ ❑ Head injury/concussion

RESPIRATORY

❑ ❑ ❑ Chronic or frequent cough

❑ ❑ ❑ Spitting up blood

❑ ❑ ❑ Shortness of breath

❑ ❑ ❑ Asthma

INTEGUMENTARY (skin, breast)

❑ ❑ ❑ Rash or itching

❑ ❑ ❑ Change in skin color/hair/nails

❑ ❑ ❑ Breast pain/lump/discharge

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____ Date of Birth: _____

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	—	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer Syndrome
- ☐ COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis Syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way • Salt Lake City, UT 84108-1214 • 1-800-469-7423 • www.myriadtests.com

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