Desert Sage
Obstetrics and Gynecology

Pt's Name _____Date of Birth_____Age _____Today's Date _____

With whom may we discuss test results or therapies? _____

At what phone number can we leave a secured voice mail?_____

1. GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination? ❒ Yes; ❒ No (If yes, please explain)

- First day of last period _____
- Duration of flow _____
- Time between periods _____
- Date of last Bone Density Scan _____
- Date of last Mammogram _____
- Date of last Pap Smear _____
- Are you sexually active? _____
- Do you use contraception? ❒ Yes; ❒ No (If yes, type?) _____
- Are you done having children? ❒ Yes; ❒ No

2. MEDICAL HISTORY: Any medical problems since your last examination? ❒ Yes; ❒ No (If yes, please explain)

- Do you take calcium? ❒ Yes; ❒ No
- List current Medications with the dosages
  (include vitamin and herbal supplements) _____
- List any Allergies to Medication _____
- Any Surgeries/Hospitalizations since your last examination? (If yes, please explain):

3. FAMILY HISTORY: Any changes to your family history since your last examination? ❒ Yes; ❒ No (If yes, please explain)
   (For example, breast cancer, ovarian cancer, uterine cancer and/or colon cancer?)

4. SOCIAL HISTORY: Any changes to your social history since your last examination? ❒ Yes; ❒ No

- Do you exercise regularly? ❒ Yes; ❒ No Current Occupation: _____
- Marital status? ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widow ❒ Same Sex Partner
- Do you smoke cigarettes? ❒ Yes; ❒ No If yes, at what age did you start?_____ Packs per day?_____
- Do you drink alcohol? ❒ Yes; ❒ No If yes, amount? _____ If yes, how often?_____
- Do you use drugs socially? ❒ Yes; ❒ No If yes, amount? _____ If yes, how often?_____
- Are you a victim of domestic violence or abuse in your present relationship? ❒ Yes; ❒ No Past Relationship? ❒ Yes; ❒ No
- Do you have a living will? ❒ Yes; ❒ No
- Do you have a medical power of attorney? ❒ Yes; ❒ No If yes, please supply a copy.

5. REVIEW OF SYSTEMS

Abdomen:
Diarrhea? ❒ Yes ❒ No Constipation? ❒ Yes ❒ No Other: _____

Genitourinary:
Frequent urination? ❒ Yes ❒ No Urinary Incontinence? ❒ Yes ❒ No Other: _____

Skin/breast:
Lumps in breast? ❒ Yes ❒ No Nipple discharge? ❒ Yes ❒ No Other: _____

Any other problems?

Completed by:_____Date:_____

Reviewed by: _____Date:_____
(Signature of Provider)

Acknowledgment of Receipt of Privacy Notice

Desert Sage

By signing below, I acknowledge that I have been provided with a copy of Desert Sage Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Desert Sage and how I may obtain access and control this information.

* _____
(Signature of Patient or Guardian)

* _____
(Print Patient name or Guardian)

* _____
(Date)

* _____
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1. _____

2. _____

3. _____

May we leave a message on an answering machine? YES NO

Preferred method of contact:

Home#_____

Cell# _____

Work# _____

Desert Sage
Obstetrics and Gynecology

5533 E. Bell Rd., Suite 103
Scottsdale, AZ 85254
TEL (602) 466-1111 FAX (602) 795-4706

Authorization for Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone: (Day) _____
_____ (Home) _____
Social Security # _____ Physician _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically expected: _____
_____

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information

From: _____ To: _____
Address _____ Address _____
_____ _____
Phone_____Fax_____ Phone_____Fax _____

II. Our Policy

As mandated by law we have 30 days to comply to all on-site medical record requests, for off-site requests the law mandates 90 day compliance.
Desert Sage OB/Gyn makes every attempt possible to expedite each release in a timely fashion.
Should you need records for an immediate purpose, please fill out the appropriate fields below.
If you are in need of same day or next day records a $15 charge will be applied.
We reserve the right to charge for multiple record requests.

Reason(s) for this authorization (check all that apply):

☐ at my request _____ ☐ other (specify) _____
_____
☐ transfer of care to _____ _____

Please indicate below if you need this information released prior to our 30 day allowance.

☐ Please have my records ready by (date) _____

This authorization ends: ☐ on (date) _____ ☐ when the following event occurs_____

III. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

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
☒ Y ☐ N	***Example: Breast Cancer***	***45***	***------***	***------***	***Aunt Cousin***	***45 61***	***Grandmother***	***53***
☐ Y ☐ N	Breast cancer *(Female or Male)*							
☐ Y ☐ N	Ovarian cancer *(Peritoneal/Fallopian tube)*							
☐ Y ☐ N	Endometrial (*Uterine*) cancer							
☐ Y ☐ N	Colon/rectal cancer							
☐ Y ☐ N	10 or more Lifetime Colon/ Rectal Polyps *(Specify #)*							
☐ Y ☐ N	Pancreatic cancer							
☐ Y ☐ N	Prostate cancer							
☐ 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, Prostate						
☐ 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) If Yes, Who? _____ What gene(s)? _____ What was the result? _____							

BREAST CANCER RISK MODEL INFORMATION

Your current height (ft/in) _____ **Your current weight** (lbs) _____

Your menopausal status:

☐ Pre-menopausal

☐ Peri-menopausal (time before menopause marked by irregular cycles)

☐ Post-menopausal: Age of onset _____

(permanent cessation of period for 12 months or longer)

Your age at time of first menstrual period _____

Your age at time of first live birth _____

Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ unknown

If yes, are you a: ☐ Current user: How many years ago did you start? _____

Intend to use for _____ more years

☐ Past user: How many years ago did you stop using? _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, do you know your diagnosis? _____

Number of daughters _____ **Number of sisters** _____

Number of maternal aunts (mother's sisters) _____

Number of paternal aunts (father's sisters) _____

HEREDITARY CANCER RED FLAGS (complete with your healthcare provider)

Personal and/or family history of any one of the following
(check all that apply)**:**

MULTIPLE: A combination of cancers on the same side of the family:

☐ **2 or more:** breast / ovarian / prostate / pancreatic cancer

☐ **2 or more:** colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)

☐ **2 or more:** melanoma / pancreatic

YOUNG: Any 1 of the following at age **50 or younger:**

☐ Breast cancer ☐ Colon/rectal cancer ☐ Endometrial cancer

RARE: Any 1 of these rare presentations at **any age:**

☐ Ovarian cancer (Peritoneal/Fallopian tube)

☐ Breast: Male breast cancer or Triple negative breast cancer (ER-, PR-, HER2- Pathology)

☐ Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology††

☐ Endometrial cancer with abnormal MSI/IHC

☐ 10 or more colon/rectal polyps*

Certain ancestries such as Ashkenazi Jewish, may have greater risk for hereditary cancer syndromes

*††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type*

Assessment criteria based on medical society guidelines. For medical society guidelines, go to MyriadPro.com

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature	Date
Health Care Provider's Signature	**Date**

Office Use Only

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If yes and accepted, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update

☐ Other: _____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com