

JOHN T. ARMSTRONG JR MD INC
3434 VILLA LANE, SUITE 360
NAPA, CA 94558
(707) 257-4317

FIRST NAME _____ LAST NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY# _____ EMAIL _____

CELL PHONE _____

HOME PHONE _____

WORK PHONE _____

REFERRED BY _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____

SUBSCRIBER NAME _____ BIRTHDATE _____

SUBSCRIBER ID # _____ SUBSCRIBER GROUP# _____

SECONDARY INSURANCE NAME _____

SUBSCRIBER NAME _____ BIRTHDATE _____

SUBSCRIBER ID# _____ SUBSCRIBER GROUP# _____

BILLING INFORMATION

RESPONSIBLE PARTY _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____

IN CASE OF EMERGENCY PLEASE CONTACT: _____

PHONE NUMBER: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Armstrong all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE _____

RELATIONSHIP _____ DATE _____

John T. Armstrong, Jr., M.D., M.S.
 3434 Villa Lane, Napa, CA 94558
 (707) 257-4317
 GYNECOLOGY HISTORY FORM

NAME: _____

TODAY'S DATE: _____

AGE: _____ OCCUPATION: _____ PRIMARY DOCTOR: _____

A. MENSTRUAL HISTORY

1. Have you reached menopause: No ___ Yes ___
 If Yes, circle how menopause occurred and go to section C: Naturally Surgically/uterus removed/ovaries removed
2. Age at 1st period: ___ Date last period started: _____ Was it normal? Yes ___ No ___
 If no, explain: _____
3. How many days do you usually flow (menstruate): ___ Flow is usually: (list # of days each):
 Light ___ Moderate ___ Heavy ___ Clots ___
4. Do you usually have cramps with your periods: No ___ Yes ___
 If Yes, are they: Mild ___ Moderate ___ Severe ___ What do you use for relief? _____
5. Number of pregnancies ___ Miscarriages ___ Abortions ___

B. CHILDBEARING/FAMILY PLANNING - If you have already reached menopause, check here and move to section C _____

1. Have you ever thought you were infertile or were you ever diagnosed with a fertility problem? No ___ Yes ___
 If yes, explain: _____
2. Are you planning to get pregnant in the future? No ___ Yes ___
 If yes, what are your plans: _____
3. Are you using a birth control method(s) now: No ___ Yes ___
 If yes, what are you using: _____
4. Have you used any other birth control method(s) in the past: No ___ Yes ___
 If yes, what: _____
5. Do you want a birth control method at your visit here: No ___ Yes ___ If yes, what method: _____
6. Have you ever had any problem, complication or unexpected pregnancy while using a birth control method:
 No ___ Yes ___ If yes, explain: _____

C. HOSPITALIZATIONS/EMERGENCY ROOM VISITS

STARTING WITH THE MOST RECENT, LIST ANY HOSPITALIZATIONS NOT LISTED ABOVE, Check here if more than 4

Month/Year	ILLNESS OR OPERATION	COMPLICATIONS	
		No	Yes, please list

D. FAMILY HEALTH HISTORY

PLACE A CHECK IN THE APPROPRIATE BOX IF EITHER YOU OR A FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING:	SELF	NATURAL MOTHER	NATURAL FATHER	NATURAL GRAND MOTHER	NATURAL GRAND FATHER	NATURAL BROTHER SISTER	CHILD
1. Heart attack or stroke before age 70, atrial fibrillation							
2. Diabetes, juvenile or adult onset, including diabetes in pregnancy							
3. High blood pressure							
4. Cardiovascular (heart/blood vessel) disease or cholesterol problems							
5. Cerebrovascular (brain/blood vessel) disease							
6. Cancer of any kind, in any organ							
7. Genetic or hereditary conditions (PKU, sickle cell Tay sachs, hemophilia, Factor 5 Leiden, other blood clotting disorders, etc.							
8. Osteoporosis, osteopenia, prior fractures							

PERSONAL HEALTH HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING:	NO	YES	IF YES, PLEASE EXPLAIN
1. lung disease, asthma, COPD, pneumonia			
2. anemia or blood disorders			
3. liver, gallbladder, stomach or bowel problems			
4. deep vein thrombosis (clots)			
5. thyroid problems, epilepsy or seizure			
6. visual problems, eye disorders, corrective lenses or contacts			
7. migraine or severe headaches			
8. severe or prolonged depression, mental or emotional problems			
9. eating disorder/bulimia or anorexia/anxiety			
10. breast disease or problems (see additional questionnaire)			
11. persistent pain or bleeding with intercourse			
12. uterine abnormalities, fibroids or polyps			
13. abnormal pap smear, CIN, dysplasia, freezing, LEEP, CONE biopsy			
14. vaginal infection, yeast, trichomonas, bacterial vaginosis, PID			
15. Chlamydia, gonorrhea, syphilis, herpes, cold sores			
16. venereal warts/genital warts/ HPV, molluscum			
17. Any other sexually transmitted disease (STD)?			
18. Any other serious illness not mentioned above?			
19. Do you want or need STD testing at your visit?			
20. Do you have any drug or medication allergies or side effects?			
21. Are you taking any drugs or medications, herbs, or supplements? Please list name, dose, schedule and provider.			
22. Do you smoke/any substance?			cigarettes/ day: ___ packs/day ___ how long: ___
23. Any substance abuse problems (drugs or alcohol)?			
24. Do you have any symptoms of vaginal infection?			
25. Any pain, frequency or urgency when urinating?			
26. Do you lose urine with a cough, sneeze, laugh or activity?			
27. Do you have any problems or questions regarding your sexuality?			
28. Do you have any gynecologic (female) problems of concern today?			
29. Is there anything else you would like us to know for your visit to assist you in your health care?			

We are pleased that you have chosen our office for your Women's Health and GYN care. Feel free to ask questions. We do not provide general health care unrelated to Women's Health and we encourage you to obtain regular medical evaluations with your primary physician. If you do not have a primary physician, we would be happy to provide you with a referral.

YOUR SIGNATURE: _____

TODAY'S DATE: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number

<input type="checkbox"/> Other _____
_____ |
|--|---|

_____	_____
Patient Signature	Date
_____	_____
Print Name	Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

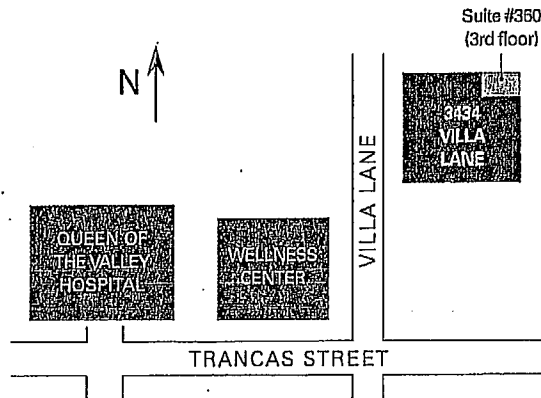
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

Our office is conveniently located at
3434 Villa Lane, Suite 360, one block east of
Queen of the Valley Hospital and 1/2 block
north of Trancas Street.



JOHN T. ARMSTRONG JR. MD Inc.

GYNECOLOGY & WOMEN'S HEALTH

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To learn more, visit:

www.JohnArmstrongMD.com