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_____

LAST 4 of SSN#_____ EMAIL_____

CELL PHONE_____

HOME PHONE_____

WORK PHONE_____

BEST TIME TO CALL (circle one): MORNING AFTERNOON EVENING

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							

(Over)

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: _____

INFORMED CONSENT

Dr. Armstrong recommends the following screening and/or diagnostic procedures during your annual or follow-up visits for certain conditions.

1) ___ Trans-vaginal ultrasound (sonogram). This study completes the standard examination to confirm normal and also accurately identifies common abnormalities such as polyps, fibroids, ovarian cysts and upper pelvic infections. It is also the best way to early identify certain silent cancers of the endocervix, uterus, fallopian tubes and ovaries. This examination is recommended by the NYU protocol.

2) ___ Colposcopy. This magnified view of the cervix and upper vagina is essential in identifying dysplasia, precancers and cancer. Pap testing and HPV alone can miss changes and abnormalities of these types (30% false negatives).

3) ___ Vulvoscopy. This magnified view of the vulva (exterior skin) is helpful to identify dysplasia, precancers and cancers early in addition to infectious and menopausal vulvitis (vulvo-vaginal atrophy). It is essential in the proper diagnosis of vulvar symptoms, skin changes, painful intercourse and recurrent UTI's.

4) ___ Breast ultrasound (sonogram). Combining this examination with mammography is the best way to diagnose breast cancer early. Mammogram alone misses 40-50% of small breast cancers especially in women with dense breasts (90% of all women). It is quick, accurate, painless (no squeeze required) and completely safe (no radiation).

Most insurances cover these exams however each insurance is unique and coverage for payment may vary.

Please circle and initial the tests above that you would like to include today.

TELEHEALTH INFORMED CONSENT (Please initial)

In responding to the Covid-19 pandemic, telephone and tele-video (Face Time) is a way to provide your individualized care privately without requiring a longer face-to-face visit.

___ I understand that Dr. Armstrong recommends the use of the above phone call to complete my visit. This improves social distancing and protection for everyone.

___ I understand that the telehealth visit is billed with the appropriate codes in the same manner as an office visit.

Name: _____ Date: _____

Print