THERMIva

Heron Med Spa

Obstetrics and Gynecology History Form

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Employer: _____ Work Phone Number: _____

Date of Birth (M/D/Y): _____ Age: _____ Gender: F_____ M_____

Height: _____ Weight: _____ lbs **(completed by staff during visit)**

Language: _____English _____Spanish _____Other: _____

Emergency contact: _____ Phone _____

Do we have your permission to:

Leave a message on your answering machine at home? YES NO

Leave a message at your place of employment? YES NO

Discuss your medical condition with any member of your household? YES NO

If yes, whom:_____ Relationship_____

Primary Care Physician: _____ Phone _____

Ob-Gyn: _____ Phone _____

Reason for Visit

Please be as specific as possible _____

How long have you had this condition? _____

Have you had any previous treatment for this condition? _____

If YES, how and when was this treated? _____

_____

Name: _____

Past Medical History: Please list all prior medical diagnosis

_____ _____
_____ _____
_____ _____

Past Surgical History: Please list all surgeries and dates

_____ _____
_____ _____
_____ _____

Please List Significant Medical Conditions in your Family, and who has/had them (breast cancer – mother, heart disease – grandfather, etc):

_____ _____
_____ _____
_____ _____

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If necessary, continue on back.

Date of Last Menstrual Period:_____

# of Days Between Menstrual Periods_____ # of Days Menstrual Period Lasts____

Are your periods: Regular: _____ Irregular:_____

Flow: Light Moderate Heavy Cramps: Mild Moderate Severe
(mark with an "**X**")

Are you having any menstrual problems? If yes, please describe _____

_____

If you are menopausal, do you have vaginal bleeding? _____

When was your last PAP test?: _____ Date of last mammogram: _____

Current Contraception: _____
If you have an IUD, it must be removed for treatment. See your Ob/Gyn.

Are you currently sexually active? _____Yes _____No

Please circle: Have you ever had any of the following STDs: None _____

Chlamydia Gonorrhea Venereal Warts Genital Herpes HPV Other_____

Name: _____

Review of Systems:
Please **X** any of the following that you are currently experiencing problems with:

Unexplained weight change	Unusual fatigue	Heat or cold intolerance
Fever	Heartburn/Indigestion	Decreased sexual desire
Dizzy spells/fainting	Trouble with balance	Frequent bruising
Chest pain	Severe joint/muscle pain	Pain or bleeding with sex
Irregular heartbeat/Palpitations	Skin lesions	Pain during urination
Coughing	Headaches	Increase in urinary frequency
Trouble breathing	Trouble sleeping	Blood in urine
Nausea	Hot flashes/Night Sweats	Urinary Incontinence
Vomiting	Pelvic pain	Vaginal discharge/odor
Constipation	Breast pain	Vulvar itching or rash
Diarrhea	Excess body/facial hair	Vaginal dryness
Blood in Stools	Premenstrual symptoms	Victim of sexual abuse

_____ _____
Signature Date

Marketing Authorization and Use of Photographs

According to federal law we must ask for your permission to send to you via email or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include special discounts). Our office **DOES NOT SELL** our patients' names.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Heron Med Spa in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Heron Med Spa in reliance on this authorization before Heron Med Spa receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact

Heron Med Spa, 321 South Patrick Street, Alexandria, VA 22314

I **DO** _____ I **DO NOT** _____

Authorize Heron Med Spa to use and disclose my Protected Health Information (PHI) to mail to me any information regarding the products, services or promotions the practice offers.

I **DO** _____ I **DO NOT** _____

Authorize Heron Med Spa services or promotions the practice offers.

_____ _____

Patient Signature Date

_____

Email Address (Please Print)

Cancellation Policy

Dear Patient:

Quite a few patients want to be seen. We know you want to be seen in a timely manner. In order to accomplish this, I schedule the appropriate number of patients to be seen in a set time. That is my responsibility to you. I ask that, in return, you respect my time as well as other patients.

If you cannot keep your appointment, CALL TO CANCEL, 24 hours before your scheduled appointment so that we may schedule another patient for that time. DO NOT send cancellations through email nor to my cell phone. **Please call the** office where your appointment is scheduled. **If we are closed, please leave a message**. All business must function with this understanding.

ALEXANDRIA: 703-549-2626

A $100 charge will be assessed for ALL NO SHOWS (un-cancelled appointments). Fees for un-cancelled appointments will be annotated to your individual invoice with payment expected before your consultation on your next visit. Please honor this policy to avoid unnecessary charges.

I have read the above and I understand that I will be charged **$100** if I fail to cancel my appointments. I also understand that this charge is in addition to any payments.

_____ _____
Signed Date

Notice of Privacy Practice Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1966**

("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practice.

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

If you feel your individuals rights, including the right to complain or if you believe your privacy rights have been violated, you may contact the HHS directly.

Patient Name_____ Relationship to Patient:_____
Print

Signature:_____ Date:_____