TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an evaluation necessary to inform you of the evaluation necessary to inform you of the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: ____________________________ Date: __________________

Printed name of patient or personal representative: ____________________________ Relationship to patient: ____________________________
Consent for Treatment and Financial Agreement

**Consent for Treatment:** I hereby authorize Obstetrics and Gynecology of Trinity to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

**Financial Agreement:** Payment includes but is not limited to: the authorization of payment directly to Obstetrics and Gynecology of Trinity benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee. I understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

**Third Party Collection:** I acknowledge that Obstetrics and Gynecology of Trinity may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer")

**Assignment of Benefits.** I hereby assign to Obstetrics and Gynecology of Trinity any insurance or other third-party benefits available for healthcare services provided to me, I understand that Obstetrics and Gynecology of Trinity has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Obstetrics and Gynecology of Trinity, I agree to forward all health insurance or third-party payments. I have fully read and understand the above payment policy. I agree to forward to Obstetrics and Gynecology of Trinity all insurance or third party payments that I receive for services rendered to me immediately upon receipt.
Medicare Patient Certification and Assignment of Benefits. I certify that any information I provide, if any, in applying for payment under Title XVII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits be made on my behalf to Obstetrics and Gynecology of Trinity by the Medicare or Medicaid Program.

Patient Initial__________

Consent to Telephone Calls for Financial Communications. I agree that, in order for Obstetrics and Gynecology of Trinity or EBO Servicers and collection agents, to service my account or to collect any amounts I may have, I expressly agree and consent that Obstetrics and Gynecology of Trinity or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Obstetrics and Gynecology of Trinity or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered valid as the original.

Patient/Patient Representative Signature:________________________________________ Date________

If you are not the Patient, please identify your relationship to the patient (circle below):

Spouse Guarantor
Parent Healthcare Power of Attorney
Legal Guardian Other (please specify) ________________________________
Authorization for release of medical information

Patient’s name: _________________________________ Date of birth: _______________________
Address: __________________________________________________________________________
City/State/Zip code: __________________________________________________________________
SS #: ____________________________________ Patient’s phone #: (____) _________________
Date of request: ___________________________ Date needed: _____________________________

I authorize OB/GYN of Trinity to release information TO:
Name of Provider: ______________________
Address: _____________________________
City, state, zip code: ____________________
Phone/Fax: ___________________________
____________________________________

I authorize OB/GYN of Trinity to obtain information FROM:
Name of Provider: ______________________
Address: _____________________________
City, state, zip code: ____________________
Phone/Fax: ___________________________
____________________________________

Purpose of request: (check one) Healthcare ___ Personal ___ Transfer of Care ___ other ___

Type of records requested: (check one)
___ Copy of entire medical record
___ Specific information (select one or more, as applicable)
___ Procedure report ____ history & physical ____ Physical therapy ____ Lab reports
___ X-ray/US reports ___ other _____________________________(please describe)

Authorization valid for: (check one)
___ this request only
___ One year from the date of this authorization OR ________. This authorization applies to
the records of the treatment received on or prior to the date of this authorization.

I understand that:
* My right to healthcare treatment is not conditioned on this authorization
* I may cancel this authorization at any time by submitting a written request to the address provided at the top of
this form, except where a disclosure has already been made in reliance on my prior authorization.
* If the person of facility receiving this information is not a health care or medical insurance provider covered by
privacy regulations, the information stated above could be disclosed.
* Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment
information requires additional authorization.
There may be a charge for the requested records.

Note: Medical records faxed in cases of medical necessity only.

Signature of patient/rep: _________________________________ Date: __________________
**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)

<table>
<thead>
<tr>
<th>CANCER</th>
<th>YOU AGE OF Diagnosis (Specify #)</th>
<th>PARENTS / SIBLINGS / CHILDREN AGE or Diagnosis</th>
<th>RELATIVES on your MOTHER’S SIDE AGE or Diagnosis</th>
<th>RELATIVES on your FATHER’S SIDE AGE or Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Y ☐ N</td>
<td>EXAMPLE: BREAST CANCER 45</td>
<td>----</td>
<td>Aunt 45 Cousin</td>
<td>Grandmother 53</td>
</tr>
<tr>
<td>☐ Y ☐ N</td>
<td>BREAST CANCER (Female or Male)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Y ☐ N</td>
<td>OVARIAN CANCER (Peritoneal/Fallopian Tube)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Y ☐ N</td>
<td>ENDOMETRIAL (UTERINE) CANCER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Y ☐ N</td>
<td>COLON/RECTAL CANCER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Y ☐ N</td>
<td>10 or more LIFETIME COLON/RECTAL POLYPS (Specify #)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Y ☐ N</td>
<td>OTHER CANCER(S) (Specify cancer type)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- | Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate

### Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

#### Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

**Personal and/or family history** of:

- Breast cancer diagnosed at/under age 50
- Ovarian (peritoneal/fallopian tube) cancer at any age
- Two or more primary breast cancers
- Male breast cancer at any age
- Triple Negative Breast Cancer (ER-, PR-, HER2-Pathology)
- Ashkenazi Jewish ancestry with an HBOC-associated cancer
- Three or more HBOC-associated cancers at any age
- A previously identified HBOC syndrome mutation in the family

*Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

‡ In the same individual or on the same side of the family

§ HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer (Gleason Score 7+)

#### Lynch Syndrome - Red Flags*

**An individual with a personal history of any of the following:**

- Colon/rectal and/or endometrial cancer before age 50
- MSI High histology on a colon/rectal or endometrial tumor before age 60
- Abnormal MSI/IHC tumor test result (colon/rectal/endometrial)
- Two or more Lynch syndrome cancers at any age
- Lynch syndrome cancer with one or more relatives with a Lynch syndrome cancer
- A previously identified Lynch syndrome or MAP syndrome mutation in the family

**An individual with a family history of any of the following:**

- A first- or second-degree relative with colon/rectal or endometrial cancer before age 50
- Two or more relatives with a Lynch syndrome cancer, one before the age of 50
- Three or more relatives with a Lynch syndrome cancer at any age
- A previously identified Lynch syndrome or MAP syndrome mutation in the family

† MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn’s-like lymphocytic reaction, or medullary growth pattern

** Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas

‡ Cancer History should be on the same side of the family

*Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

### Cancer Risk Assessment Review  (To be completed after discussion with 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, which test? BRACAnalysis® with Myriad myRisk® Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk
- Single Site Testing Myriad myRisk Update Other:__________
- Follow-up appointment scheduled: YES NO Date of Next Appointment: ___________________
OBGYN of Trinity
Health History Form

Name_____________________________________________ Date of Birth _________________
Age___________________________ Today’s date _________________

Check, circle, or fill in ALL answers that apply (you may mark more than one choice). Please mark 'none' if it does not pertain to you.

CURRENT MEDICATION

<table>
<thead>
<tr>
<th>Current Medication</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL HISTORY

Do you currently have (or have had) any of the following?
- None
- Asthma
- Atrial fibrillation
- Adult onset diabetes
- Anxiety
- Arthritis
- Breast cancer
- BV (bacterial vaginosis)
- Bipolar
- Bronchitis
- Cancer (type)______________
- Chicken pox
- COPD
- Compulsive dis.
- Colon
- CMV
- Depression
- DVT
- Elevated cholesterol
- GERD
- Glaucoma
- Heart attack
- Hypertension
- Hepatitis
- HIV/AIDS
- Hypothyroid
- Heart disease
- Infertility
- Migraines
- Melanoma
- Kidney stones
- Seizures
- Measles
- Recurrent UTI
- Liver disease
- PMS/PMDD
- Insomnia
- Yeast infections
- Suicide attempt

Please list any other medical conditions that you have or have had in the past:
________________________________________________________________________
________________________________________________________________________

ALLERGIES

<table>
<thead>
<tr>
<th>Medication</th>
<th>Type of Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GYNECOLOGICAL HISTORY

Age of onset of periods___________ First day of last menstrual period ___/___/___

Regularity of periods
- Irregular
- Not sure
- Every 28 days
- 30-42 day cycle
- Longer the 42 day
- Every 14 days
- Menopausal
Current Contraception
☐ Oral birth control pills  ☐ IUD (type) _____________________________
☐ Depo Provera  ☐ Nuvaring
☐ Pull out method  ☐ Nexplanon (Implant)
☐ Permanent sterilization
Which brand of birth control pills are you currently taking? ________________
Will you need a refill today  ☐ Yes ☐ No

Menopause
Age of onset of menopause _______________
Do you have any menopausal symptoms?
☐ None  ☐ Hot flashes  ☐ Night sweats  ☐ Vaginal dryness
☐ Mood changes  ☐ Memory loss  ☐ Insomnia  ☐ Weight gain

Sexual concerns
☐ None  ☐ Painful sex  ☐ Decreased libido
☐ No orgasm  ☐ Burning  ☐ Vaginal dryness

Date of last mammogram _______________ ☐ Normal  ☐ Abnormal
Date of last bone density scan ___________ ☐ Normal  ☐ Abnormal
Date of last colonoscopy _________________ ☐ Normal  ☐ Abnormal
Date of last pap smear _________________ ☐ Normal  ☐ Abnormal

History of STD
☐ None  ☐ Chlamydia  ☐ Gonorrhea  ☐ HPV  ☐ Warts
☐ HIV  ☐ PID  ☐ Syphilis  ☐ Trichomonas
☐ HSV (herpes)

History of Abnormal Pap Smear
☐ None  ☐ ASCUS  ☐ LGSIL  ☐ HGSIL
☐ No treatment  ☐ Conization  ☐ Colposcopy  ☐ LEEP
Follow up pap smears:  ☐ Normal  ☐ Abnormal

OBSTETRIC HISTORY
Past pregnancies:

<table>
<thead>
<tr>
<th>Total # of pregnancies</th>
<th>Total # of miscarriages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of Full term births</td>
<td>Total # of Ectopic/tubal pregnancies</td>
</tr>
<tr>
<td>Total # of Preterm births (&lt;36 weeks)</td>
<td>Total # of Multiple births (twins)</td>
</tr>
<tr>
<td>Total # of Induced abortions</td>
<td>Total # of Living children</td>
</tr>
</tbody>
</table>
For each child, please list the following:

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
<th>Child 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth weight</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Type of delivery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Anesthesia</td>
<td></td>
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<td></td>
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<tr>
<td>Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For our moms who are currently pregnant:

Baby's father's name ____________________________________________
Father's phone number __________________________________________

**SURGICAL HISTORY**

- □ NONE
- □ Appendix
- □ Tonsils
- □ Gallbladder
- □ Tubal ligation
- □ Laparoscopy
- □ Bladder surgery
- □ Orthopedic
- □ Hysterectomy
- □ Lumpectomy
- □ Mastectomy
- □ Abortion
- □ Other ________________________________

**HOSPITALIZATIONS**

- □ NONE
- □ Car accident
- □ Head injury
- □ Fracture
- □ Illness ________________________________

**FAMILY MEDICAL HISTORY**

Please include ANY family members with the following medical condition

<table>
<thead>
<tr>
<th>Breast Cancer □ Yes □ No</th>
<th>Birth Defects □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which relative:</td>
<td>Which relative:</td>
</tr>
<tr>
<td>Ovarian cancer □ Yes □ No</td>
<td>High blood pressure □ Yes □ No</td>
</tr>
<tr>
<td>Which relative:</td>
<td>Which relative:</td>
</tr>
<tr>
<td>Uterine cancer □ Yes □ No</td>
<td>Heart disease □ Yes □ No</td>
</tr>
<tr>
<td>Which relative:</td>
<td>Which relative:</td>
</tr>
<tr>
<td>Osteoporosis □ Yes □ No</td>
<td>Diabetes □ Yes □ No</td>
</tr>
<tr>
<td>Which relative:</td>
<td>Which relative:</td>
</tr>
<tr>
<td>Colon cancer □ Yes □ No</td>
<td>Psychiatric disorder □ Yes □ No</td>
</tr>
<tr>
<td>Which relative:</td>
<td>Which relative:</td>
</tr>
</tbody>
</table>
SOCIAL HISTORY
Marital status:  □ Married  □ Single  □ Divorced  □ Separated
□ Widowed  □ Domestic partner

Occupation: ______________________________________________________________

Exercise:  □ NONE  □ Occasional  □ Moderate  □ Heavy

Diet:  □ Regular  □ Vegetarian  □ Vegan  □ Gluten free
□ Cardiac diet  □ Diabetic diet

Tobacco Use:  □ Never  □ Former smoker  □ Current smoker________

Alcohol Use:  □ NONE  □ Occasional  □ Moderate  □ Heavy

Drug Use:  □ NONE  □ Marijuana  □ Cocaine  □ Heroin
□ LSD  □ Methadone  □ Prescription drug abuse

Abuse/Domestic violence:  □ NONE  □ History of rape
□ Abuse as child  □ Physical abuse

Current abuse____________________________________________________________

Other specialty doctors you see

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Name</th>
<th>Location</th>
<th>Phone number</th>
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