Date of Service:

Patient Name:

DOB:

Please complete the following questionnaire that reviews the health systems important for your wellbeing, even if they may not be associated with your visit today. Your doctor will then ask you pertinent questions based on your answers. When completing the sections please put a (+) for yes within the brackets next to the symptom, **if it has been a problem for you within the last 30 days.**

REVIEW OF SYSTEMS:

Constitutional: ( )fever, ( )night sweats, ( )hot flashes( )chills, ( )fatigue, ( )weight gain, ( ) unintentional weight loss

Mouth, Throat: ( )mouth sores, ( )dental problems, ( ) pain

Neck: ( )neck lumps, ( )neck swelling

Respiratory: ( )shortness of breath, ( )cough, ( )wheezing

Cardiovascular: ( )chest pain, ( )palpitations, ( )lower extremity swelling

Breast: ( )breast lump, ( )breast pain, ( )nipple discharge

Gastrointestinal: ( )abdominal pain,( ) bloating, ( )nausea, ( )vomiting, ( )constipation, ( )diarrhea

Urinary: ( )burning, ( )urinary hesitancy, ( )increased urinary frequency, ( )increased nighttime urination, ( )urge symptoms, ( )urinary leaking, ( )blood in urine

Genital/Reproductive: ( )difficulty with orgasms, ( )low libido, ( )pain with intercourse, ( )heavy bleeding, ( )bleeding between menstrual periods, ( )excess pain with menses, ( )irregular menses, ( )bleeding after menopause, ( )vaginal discharge, ( )vaginal odor, ( )vulvar pain, ( ) itching/irritation/burning

Musculoskeletal: ( )muscle pain, ( )muscle weakness, ( ) joint pains

Neurological: ( )headaches, ( )fainting

Behavioral Health: ( )change in mood, ( )depression, ( )anxiety

I would like to have a chaperone present for the exam portion of my visit: ( )Yes ( )No

FOR RETURNING PATIENTS ONLY: since your last visit..........

1. List any changes in your medications:______________________________________
   ____
2. List any new allergies:______________________________________
3. List any new medical illnesses/surgeries:______________________________________
4. List any additional changes you would like your Doctor to know about:______________________
   ____

Edited 02/2021CA

Colene Arnold, MD Gynecology & Associates
40 Concord Road Unit 4, Lee, NH 03861
Phone: 603-230-2433; Fax: 603-658-0938

COLENE ARNOLD, MD GYNECOLOGY & ASSOCIATES
GYNECOLOGY QUESTIONNAIRE

NAME:______________________________ DOB:__________ AGE:_____ DATE:__________

RACE:__________ ETHNICITY:__________ PRIMARY LANGUAGE:__________ PCP:____________

MEDICAL HISTORY:

- ☐ ADHD
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune cond. ________
- ☐ Bleeding disorder
- ☐ Cancer________________
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type 1 or 2
- ☐ Elevated Cholesterol
- ☐ Eczema or Psoriasis
- ☐ Gerd/Reflux
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Infectious Disease________
- ☐ IBS- Constipation
- ☐ IBS- Diarrhea
- ☐ Liver Disease
- ☐ Migraines w/ or w/o aura
- ☐ Seizures
- ☐ Trauma

GYNECOLOGIC HISTORY:

- ☐ Abnormal paps, when____________________
- ☐ Abnormal vaginal bleeding
- ☐ Irregular menses
- ☐ Dysmenorrhea (painful periods)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Chlamydia or gonorrhea
- ☐ Herpes oral___; genital___
- ☐ HPV/genital warts
- ☐ Pelvic Inflammatory Disease, when____________
- ☐ Infertility, Type____________________
- ☐ Painful sex
- ☐ Problems with sexual desire
- ☐ Problems with orgasms
- ☐ Vulvar disorders
  - ☐ vestibulitis/vulvodynia
  - ☐ Lichen sclerosus
  - ☐ Lichen planus
- ☐ Recurrent vaginal infections, Type____________
- ☐ Spasm of the pelvic floor
- ☐ Urinary incontinence
- ☐ Frequency of Urination
- ☐ Urgency of Urination
- ☐ Urinary Tract Infections
- ☐ Interstitial Cystitis
- ☐ Gynecologic cancers____________________
- ☐ Osteopenia or Osteoporosis

SOCIAL HISTORY:

1. Tobacco: Never _____ Past/year quit___________
   Current, cig/day______ Vaping_____________
2. Alcohol: How many drinks per week___________
   Average # at a time____ More than 6?_______
3. Use of street drugs?____________________
4. Misuse of prescription drugs?______________
5. History of Domestic Violence?______________
6. History of Sexual Violence?_______________
7. Highest level of Education:_______________
8. Occupation:__________________________
9. Gender Identity:_______________________
10. Sexual Orientation:____________________
11. Preferred Pronouns:____________________
11. Nutritional Habits: Healthy vs
    Healthy some of the time vs Unhealthy
12. Exercise: Times per week_______________
    Minutes per session_____________
13. ___Single ___Married ___ Divorced ___ Sig Other
    ___Widowed

ALLERGIES/REACTIONS:

Medication________________________
____
____
____

MEDICATIONS/SUPPLEMENTS: with dose and frequency

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

COLENE ARNOLD, MD GYNECOLOGY & ASSOCIATES
GYNECOLOGY QUESTIONNAIRE

FAMILY MEDICAL HISTORY

MOTHER:____

FATHER:____

SIBLINGS:____

MATERNAL GRANDMOTHER:__________________ MATERNAL GRANDFATHER__________________

PATERNAL GRANDMOTHER:__________________ PATERNAL GRANDFATHER__________________

SURGICAL HISTORY: **DATE**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

MENSTRUAL CYCLE/REPRODUCTIVE HISTORY:

1. Age at first period______ If menopausal, age of menopause______
2. How often do you get your menstrual cycle? Every_____days, lasting_____days.
3. Are your cycles regular or irregular?
4. Do you have bleeding in between your menstrual cycles? YES. NO
5. On your heaviest day how many pads or tampons do you use?____________________
6. Do you have pain with your menstrual cycles? YES NO
7. What do you use for your pain? ______________
8. How often do you perform self breast exams?
9. Are you sexually active? Please circle answer: Never Not currently Yes

PREVENTATIVE CARE: **RESULTS/Where performed**

Last Pap:______________________________

Last Mammogram:______________________________

Last Thermogram:______________________________

Last Colonoscopy:______________________________

Last Bone Density:______________________________

Last Cholesterol screen:______________________________

Last routine labs:______________________________

Received Gardasil Vaccine: Yes____ No_____

10. Do you ever experience pain with sex? YES or NO
11. Do you feel that your sexual desire is adequate? YES or NO
12. Are you satisfied with your ability to orgasm? YES or NO
13. Current method of Birth control? ______________________________
14. Previous methods of Birth Control? ______________________________
15. Has anyone ever pressured or forced you to engage in sex? YES or NO
16. Are you now or have you ever been emotionally or physically abused? YES or NO

PREGNANCY HISTORY: Please list all pregnancies including miscarriage, abortions and ectopics.

Birthdate	Weeks	Length of labor	Baby's weight	Sex	Type of Delivery	Anesthesia	Complications

Patient Signature:______________________________ Date:______________

Guardian Signature:______________________________ Date:______________

Physician Initial:________ Date:______________

40 Concord Road, Unit 4
Lee, NH 03861
Website: www.colenearnoldmd.com

Phone: (603) 230-2433
Fax: (603) 658-0938

Authorization to Release and Disclose Medical Information

**This authorization expires one year from the signed date below.*

PATIENT INFORMATION

Name:______________________________DOB:____________

Address:____

City:____________________State:_____Zip Code:__________

Phone Number(s): *Cell Phone*______________ *Home*____________

RELEASE MEDICAL RECORDS *FROM*

- ☐ Colene Arnold, MD Gynecology & Associates (Dr. Colene Arnold *OR* Dr. Teresa Vanderlinde)
- ☐ Name of Company: ______________________________

  Address:________________________City:______________

  State:_____ Zip Code:________Phone:______________Fax:______________

RELEASE MEDICAL RECORDS *TO*

- ☐ Colene Arnold, MD Gynecology & Associates (Dr. Colene Arnold *OR* Dr. Teresa Vanderlinde)
- ☐ Patient/Parent/Guardian (PICK UP or FAX ***please circle**)
- ☐ Name of Company: ______________________________

  Address:__________________City:______________

  State:_____ Zip Code:________Phone:______________

MEDICAL RECORDS TO RELEASE

- ☐ All of my healthcare information **including but not limited to identifying information, personal and family history diagnoses, treatments, and medications.*
- ☐ The following specific health care information ***please circle***

  Evaluations - Progress Notes - Discharge Notes - Treatment Notes

  Patient Intake Forms - Billing Information
- ☐ I authorize release of records pertaining to ***please circle***

  Mental Health - Alcohol and/or Drug Abuse - HIV/AIDS

  Psychiatric/Psychological Evaluations - Chemical Dependency Evaluations

  Please specify ANY healthcare information you DO NOT want released below:

PURPOSE OF DISCLOSURE

- ☐ Transfer of Care
- ☐ Continuity of Care
- ☐ Legal Purposes
- ☐ Personal Copy
- ☐ Insurance/Disability
- ☐ Other: ______________________

Patient Signature:______________________________**Date**__________

Patient HIPAA Acknowledgement and Consent Form

Patient Last Name	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practices/Clinics

I acknowledge that I have received the practice Notice of Privacy Practice which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1.			
2.			
3.			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communication about My Healthcare

I agree the Provider or an agent of the Provider may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated

representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

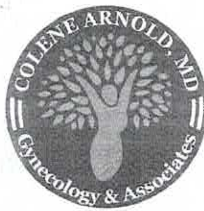
Note: This practice uses an Electronic Health Record that will update **all your demographics and consents** to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Telehealth Informed Consent

The following information applies to telehealth services provided by Colene Arnold, MD Gynecology & Associates medical providers. Telehealth involves the use of an encrypted video application to communicate with your medical provider at our practice.

Telehealth visits will be done over a HIPPA-compliant audio/video platform or by telephone. Information and notes from these visits will be stored in the same way as face-face visits or sessions. All patient policies and procedures of Colene Arnold, MD Gynecology & Associates continue to apply. Your insurance will be billed as it is during face-to-face visits or sessions. Any copayments associated with your insurance will be billed to you. If your insurance is found to be inactive you are fully financially responsible for the expenses of the visit or session. The laws that protect the confidentiality of your medical information in face-face visits or sessions also apply to telehealth visits. It is your responsibility to ensure the confidentiality of your visit or session in the environment in which you participate.

Please understand that there are both risks and benefits associated with telehealth. Benefits may include increased access for those who may be challenged by geographic location, transportation, and/or other barriers. Risks related to telehealth visits include certain limits to confidentiality in electronic communication. These risks include, but are not limited to: 1) the possibility — despite reasonable efforts on the part of my medical provider— that the video (or telephone) interaction between you and your provider could be interrupted due to technical failures or faulty Internet connection; and 2) the potential for confidentiality breaches due to technical failures. Furthermore, when using the video platform, the contents of your medical provider's computer are encrypted to further ensure your privacy and confidentiality.



Release of Information

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) may be made available to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

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

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Colene Arnold, MD Gynecology & Associates
40 Concord Road Unit 4, Lee, NH 03861
Phone: 603-230-2433 Fax: 603-658-0938

Consent to Treat

I hereby authorize Colene Arnold, MD Gynecology & Associates staff, including physicians, nurse practitioners, nurses and medical assistants, of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the physicians, including consultants, associates, and assistants of the physician's choice.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Financial Responsibility:

PLEASE NOTE THAT PAYMENT IS EXPECTED IN FULL AT THE TIME OF YOUR VISIT. ANY PAST BALANCE WILL NEED TO BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS.

I hereby authorize I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon the time of your appointment and are payable to Colene Arnold, MD Gynecology & Associates and further understand should my account become delinquent, I shall pay any expenses incurred by Colene Arnold, MD Gynecology & Associates in the collection of that account, if any.

I understand that I am financially responsible for the total charges accrued from any missed appointments ***IF I have not notified the office of Colene Arnold, MD Gynecology & Associates at least 24 hours in advance of my cancellation.*** **($100 cancellation fee for 60 minute and 90 minute specialty visits and a $50 cancellation fee for routine visits and no-shows).**

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Colene Arnold, MD Gynecology & Associates
40 Concord Road Unit 4, Lee, NH 03861
Phone: 603-230-2433 Fax: 603-658-0938

HIPAA notice of privacy

Colene Arnold, MD Gynecology & Associates LLC, 40 Concord Road Unit 4, Lee, NH 03861

[THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY]

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 06/01/2020, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or

o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Leah M. Healy, Leah@colenearnoldmd.com

Telephone: 603-230-2433

Address: 40 Concord Road Unit 4, Lee, NH 03861