for Women
Holistic Gynecology and Conscious Wellness

Elizabeth G. Motyka, MD, FACOG
Board Certified, American Board of Obstetrics and Gynecology

Welcome to my practice. Enclosed are some forms for you to fill out before your appointment. To help me gain a complete picture of your past and present health concerns, please include as much information as you can. I think you will find the process of completing the questionnaires useful and it may stimulate questions that can be addressed at the time of your visit.

Be sure to bring the forms with you to your appointment along with any other medical records or reports that may be useful. If we will need to obtain records from another health care provider for you, please bring their contact information with you including phone, address, and fax numbers. Also, be sure to bring any medications and or supplements that you may be taking.

All new patients are required to bring a government issued photo ID. This is in order to comply with federal regulations regarding identity theft. Also please bring any Insurance cards you wish to use for your visit.

Directions to our office are enclosed.

I do my best to be sure you are well taken care of, so please feel free to call if you need help. I look forward to seeing you on the day of your appointment.

Sincerely,
Elizabeth G. Motyka, MD

MedicalRecord#:_____(office)
Date_____

Personal Health History Form

Name: Last_____First_____Middle/Maiden_____
Age_____ Gender Identification_____
Please describe the major reason for this visit?

Please list any other significant concerns that you currently have:

Medical History
Have you had any major illnesses, hospitalizations, or surgeries that have caused you to miss work, school, or change your lifestyle? Yes ____ No ____If yes, please list and date

Describe below any past problems or current concerns regarding reproduction or sexual function

Please list your pregnancies below:

TYPE	Number	Associated problems/comments	AGE
Vaginal Births			
Caesarian Sections			
Miscarriages			
Terminations			

Do you have any adopted children?_____ Ages_____
When was the first day of your last period? _____
How often do you have a period? _____How long does each period last? _____
Do you have any other vaginal discharge that is bothersome ?_____We recommend safe sexual practices. Are you currently sexually active? ___ Do you practice safe sex? _____Would you like testing for STD's?___Do you need a pap today_____Do you have a regular partner? _____ Is your partner male or female or both? Are you planning a pregnancy now? _____If not, what birth control method are you using? _____Would you like information about other methods? _____

What **allergies** do you have currently (foods, medications, environmental, or latex)? What type of reaction do you have?

What **medications** do you currently take and why? (Include over the counter medications, vitamins, and herbal remedies)

Medications Dose Frequency Reason for taking

What alternative health remedies do you use? (Massage, acupuncture, etc)

Family History *Have any of your relatives had the following diagnoses?*

	Yes	Which relative
Heart disease		
Stroke		
High blood pressure		
High Cholesterol		
Diabetes		
Thyroid disease		
Breast cancer		
Other Cancer(s)		
Depression		
Mental Health Hospitalization		
Suicide attempt		
Osteoporosis		

Social History

We recommend limiting tobacco use.
How much tobacco do you use a day? _____
For how many years_____
How much alcohol do you use a day? _____
What recreational drugs do you use? _____
How often?_____

Please circle you current stress level no stress 1 2 3 4 5 6 7 8 9 10 severe

What is you biggest source of stress right now?

What do you do to relieve stress?

What are the things that bring you your greatest happiness?

Are you currently employed? Yes__ No __If yes, what is your job and are you concerned about any work related health hazards?
Do you like your job? Yes _____No _____
Do you have any financial concerns that limit your ability to seek health care? Yes_____No_____
What is your Marital Status: Single__Co-habitating __Married__Divorce_Widowed_
What cultural, religious, or spiritual issues do you have that might influence your health care?

Preventive Health Care and Screening

When was your last tetanus shot? _____ last pap smear?_____ mammogram?_____
breast self exam?_____ cholesterol screen? _____ vitamin D_____
dental check?_____bone scan? _____ colonoscopy?_____
Do you follow a healthy diet? _____If not, would you like information on nutrition or weight control?_____
Consider your physical activity during the last month and circle the statement that best describes your exercise habits:

How often do you exercise aerobically?	How long do you exercise?
Daily or almost daily	Over 45 minutes per session
3 - 5 times a week	30 – 45 minutes per session
1 - 2 times a week	20 – 30 minutes per session
A few times a month	10 -20 minutes per session
Less than once a month	Less than 10 minutes per session

Circle the types of activities that you perform? Strength Training, Walking, Sports, Running, Yoga, Swimming, Cycling, Housework/Yard work, Hiking, Flexibility Exercise,
Other: _____
Would you like information on exercise, fitness, strength, or flexibility training? _____
How many hours do you sleep each night? _____
We recommend safety belt use in cars and helmets with motorcycles.
Do you wear a safety belt or helmet when driving? _____
We recommend avoiding alcohol when driving. Do you drink alcohol and drive a car or boat?_____
Have you ever been sexually or physically abused? _____
Is anyone hurting you now?_____
Is there a firearm in your house? _____ We recommend safe storage or removal.
We recommend use of smoke detectors in the home. Do you have a smoke detector? ____
We recommend limiting sun exposure. Do you have recreational or occupational sun exposure? _____
If you are a woman of child bearing age we recommend O.4 mg of folic acid/day. If you are ‹18 yrs old or post menopausal we recommend 1500 mg of calcium /day.

Risk Factor Assessment
Please check any of the following risk factors to cervical cancer that apply to you
___Prior history of abnormal pap ____History of a blood transfusion
___Exposure to any sexually transmitted ____Onset of first sexual activity prior to age 16
diseases- including herpes,HIV, HPV, ____ Smoking ____DES
gonorrhea, syphilis, or chlamydia ____› 5 sexual partners in a lifetime

Please check any risk factors for osteoporosis that apply to you

____Use of steroids current or past ____Smoking
____Family history ____Underweight
____ Caucasian

Please check any of the risk factors for diabetes that apply to you

____Family history ____Native American, African American, Asian
____History of diabetes in a pregnancy or delivery of a baby >9 lbs ____High Blood pressure
____Overweight

Please check any of the following risk factors for breast cancer that apply to you

____Family history ____History of menstruation prior to age 12
____History of menopause after age 52 ____History of a biopsy showing hyperplasia

Please check any of the following risk factors for heart disease that apply to you

____Smoking ____History of high cholesterol in you or a family member
____History of heart attack in a family member especially if <55 yrs of age ____Diabetes

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. Thank you.

Cardiovascular

____Blood pressure ____Chest pain-angina
____Heart ____ Failure
____Heart attack ____Blood vessels
____Murmur-valve problem

Musculoskeletal

____ Joints (arthritis)
____ Muscles
____ Bones

Respiratory

____ Lungs (Breathing problem, Asthma, TB)
____ cough ____ wheezing
____ shortness of breath

Dermatologic

____ Skin/rashes, moles, ulcers
____ Lymph nodes
____ Hair loss or excess hair

Gastrointestinal

____ Abdomen (constipation, ulcers)
____ Rectum (hemorrhoids, incontinence)
____ Liver (hepatitis)

Neurological

____ Loss of sensation ____ Loss of strength
____ Memory loss ____ Dizziness/fainting
____ Migraines or headaches ____seizures

Endocrine

____ Diabetes ____PMS
____ Thyroid

Hematologic

____ Anemia ____ Blood clots
____ Easy Bleeding ____ HIV
____ Blood transfusion

Eyes, Ear, Nose, Throat

____ Eyes ____ Mouth
____ Ears ____ Throat
____ Nose and Sinuses

Genitourinary

____ Breast ____ Vagina
____ Uterus ____ Tubes
____ Ovaries ___ Cervix
_____ Pelvic Infection
____ Kidney

Sexual health

____trouble with orgasm
____pain with sex
____ vaginal dryness
____bothersome low libido
____hot flashes/ night sweats
____satisfaction with partner

Psychiatric

____ Schizophrenia ____ Anxiety
____ Depression ____ Insomnia

Other

Signature _____

Patient Information(Please Print)

Patient_____

Last Name First Name Middle/Maiden name

Responsible Party (If a minor)_____

Address _____ City _____ _____ State_____Zip_____

Birthdate _____ Age ____ Sex ____ Marital Status_____ SSN#_____

Patient Employed By_____Occupation _____

Home Phone_____Business Phone _____Cell_____

Fax number_____ E-Mail Address_____

How would you like our office to contact you with detailed results and medical information?

Mail_____ home phone_____ work phone_____ fax_____ cell_____

Who may we thank for referring you?_____emergency contact? _____

Responsible Party(If other than the patient, we MUST HAVE primary insured info.)

Last Name_____ First Name_____Initial____

Relationship_____Birthdate_____SSN#_____ Phone_____

Address (if different)_____City_____State____Zip_____ __

Insurance

Name of Primary Insurer (if any)_____

Insurance ID #_____ Group #_____

Name of Secondary Insurer (if any)_____

Insurance ID#_____Group # _____

Assignment and Release

I,the undersigned certify that I (or my dependent) have insurance with _____ and assign directly to Dr. Motyka 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/Guardian Date

For Women, PA Elizabeth G. Motyka, MD

OFFICE POLICIES

Contact and Appointment info: We are open for appointments, prescription refills and general questions Monday through Friday 9:00 am-12:30pm and 1:30pm to 5:00 pm. Please give us at least 24 hours advance notice for a cancellation. A $30.00 missed appointment fee will be charged for cancellations without a 24 hour notice. I reserve the right to discontinue my services after three missed appointments without notice. Refills cannot be filled after hours, as I will not have access to your chart.

Emergencies: I can be reached by calling 919-401-4515 during business hours. For emergencies after hours, please call our office number and you will be directed how best to reach the doctor on call. For hospital emergencies my call group uses WakeMed Hospital. For less urgent situations, you may leave a message at the office number 919-401-4515. Every effort will be made to return calls promptly by the next business day. If the situation warrants or there is a delay in returning a message, please seek help at the nearest emergency room or urgent care center.

Physician Responsibilities: I am a solo practitioner sharing the building with other practitioners. We are not employees of one another or in partnership with each other. I maintain a separate practice with separate records, billing and responsibilities for your care. Please be aware of this when making appointments and interacting with the other people in the building.

Confidentiality: Our work together is completely confidential, as are your records. Your social security number is required for billing and financial responsibility, this information is protected under the same confidentiality laws as your personal medical records. Your explicit permission is required to release information about your treatment to doctors, insurance companies, family members or others (including other practitioners). You may have access to your medical records for review if you wish. You will be asked to sign a HIPPA form at your first vist. If you would like to see the full privacy policy it is available at our office or on our website: www.forwomengyn.com

About Financial Arrangements and Insurance: I participate in many insurance plans including Blue Cross/Blue Shield, United Healthcare, Cigna and others. I am not taking new Medicare or Medicaid patients at this time. You may want to check with your insurance company about your specific benefits. Payment of any copay and or coinsurance is due at the time services are rendered. I accept cash, checks, MasterCard, or Visa. Returned checks are subject to an additional collection fee of $20.

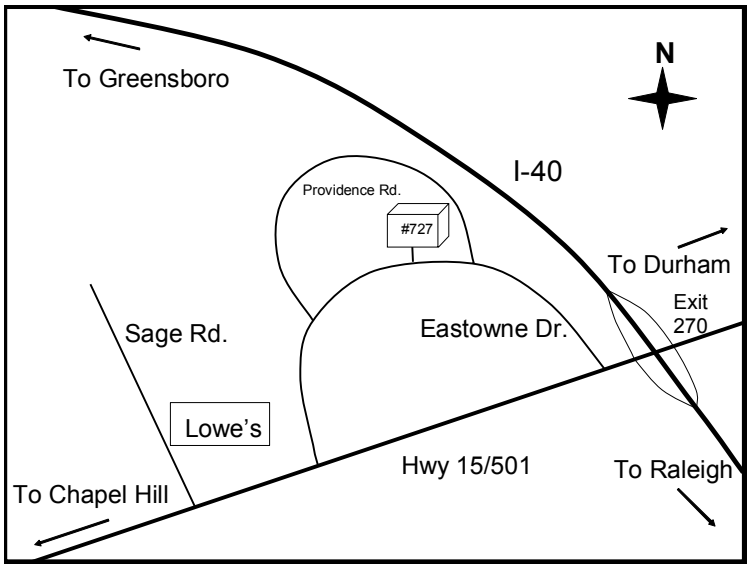
Policy on Supplements and Product for Sale and Off label Use of medications and supplements: We offer various nutritional/ herbal products, informational supplies, and medical equipment for sale which may be offered at various other locations, possibly including local stores. We are aware that many potential sources of purchase have excellent products including the very ones we sell, and we encourage you to shop around and compare. When one of the items that we recommend to you is available elsewhere *we want you to feel no pressure to buy these products from us.* These products are offered by our office for three reasons, 1) your convenience, 2) to provide you access to products that are sold only through doctor's offices, and 3) because we think the products are especially good ones. Some therapies I suggest may not be considered conventional medical treatment. I offer such off label or alternative treatments because I believe they be of potential benefit. There is no guarantee of benefit.

Phone Policy: To best manage patient needs and the large volume of patient phone calls that come in each day for Dr. Motyka, phone calls from patients with questions that can be handled in 5 min or less of Dr Motyka's time will be accommodated free of charge. For complicated or multi issue questions which need greater time and attention, patients will be asked to either schedule an office visit or phone consultation appt. Phone consultations are not covered by insurance. Payment for phone consultations can be made by personal credit card at the time of the visit. (280.00/hr)

Discrimination: We do not tolerate discrimination against age, color, religion, sex, sexual preference, gender identity, or reproductive choices. We do however maintain the right to terminate care in the setting of violence, abusive or threatening behavior, noncompliance with care and or office policies, and failure to make payment arrangements.

Please Sign to indicate that you have read and agree to office policies:_____

Directions to the Office



From Durham:

- Take 15-501 South to Chapel Hill.
- Turn right at first light after crossing I-40 onto EASTOWNE DR.
- Turn right into first driveway just after Providence Rd.
- **727 EASTOWNE DR. SUITE 200 A**

From Raleigh/Cary and Points East:

- Stay on I-40 W past Raleigh, the airport and Research Triangle.
- Take the 15-501 - EXIT 270 toward Chapel Hill/ Durham .
- Turn LEFT onto 15-501 South to Chapel Hill.
- Turn right at first light after crossing I-40 onto EASTOWNE DR.
- Turn right into first driveway just after Providence Rd.
- **727 EASTOWNE DR. SUITE 200 A**

From Greensboro and Points West:

- Take I-40 East/I-85 North.
- Take RIGHT onto I-40 E when road splits.
- Take 15-501 - EXIT 270 - toward Chapel Hill/Durham.
- Turn RIGHT onto 15-501 South toward Chapel Hill.
- Turn RIGHT at first light, EASTOWNE DR.
- Turn right into first driveway just after Providence Rd.
- **727 EASTOWNE DR. SUITE 200 A**

From Hillsborough:

- Take I-40 E toward Raleigh.
- Take 15-501 - EXIT 270 - toward Chapel Hill/Durham.
- Turn RIGHT onto 15-501 South toward Chapel Hill.
- Turn RIGHT at first light, EASTOWNE DR.
- Turn right into first driveway just after Providence Rd.
- **727 EASTOWNE DR. SUITE 200 A**

From Pittsboro:

- Take 15-501 to Chapel Hill.
- Turn RIGHT to continue onto 15-501 N.
- Turn LEFT onto EASTOWNE DR. after passing LOWE'S and BORDER'S.
- Turn LEFT into driveway.
- **727 EASTOWNE DR. SUITE 200 A**