



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.

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

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

Please list your pregnancies below

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

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 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)

<i>Family History</i>	<i>Have any of your relatives had the following diagnoses?</i>	
	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 your current stress level no stress 1 2 3 4 5 6 7 8 9 10 severe

What is your 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-habiting ___ 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? _____

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 0.4 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 diseases- including herpes, HIV, HPV, gonorrhea, syphilis, or chlamydia

___ Onset of first sexual activity prior to age 16

___ Smoking ___ DES

___ > 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 High Blood pressure
 or delivery of a baby >9 lbs 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
 History of heart attack in a or a family member
 family member especially if Diabetes
 <55 yrs of age

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

Respiratory

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

Gastrointestinal

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

Endocrine

- Diabetes
 Thyroid

Eyes, Ear, Nose, Throat

- Eyes Mouth
 Ears Throat
 Nose and Sinuses

Psychiatric

- Schizophrenia Anxiety
 Depression Insomnia

Other

Musculoskeletal

- Joints (arthritis)
 Muscles
 Bones

Dermatologic

- Skin/rashes, moles, ulcers
 Lymph nodes

Neurological

- Loss of sensation Loss of strength
 Memory loss Dizziness/fainting
 Migraines or headaches seizures

Hematologic

- Anemia Blood clots
 Easy Bleeding HIV
 Blood transfusion

Genitourinary

- Breast Vagina
 Uterus Tubes
 Ovaries Cervix
 Pelvic Infection
 Kidney

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. I reserve the right to discontinue my services after three missed appointments without the 24 hour advance 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 visit. 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: We offer various nutritional 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.

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:

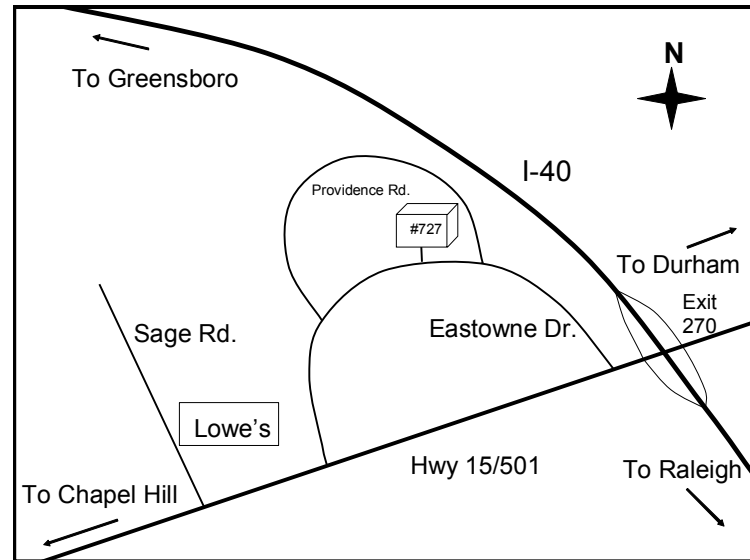
- Take 15-501 South to Chapel Hill.
- Turn right at first light after crossing I-40 onto EASTOWNE DR.
- Turn right into first driveway just after Providence Rd.
- **727 EASTOWNE DR. SUITE 200 A**

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**