

**○ PMG OB-GYN HEALTH CENTER**

**Located in the Providence Professional Plaza  
on the third floor off of the gold elevator**

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**Dear Patient,**

We look forward to seeing you at your next appointment. Since you are scheduled for an annual exam, we thought the following information might be helpful.

Health plans differ as to the types of services they cover. Some health plans cover only services determined to be medically necessary for the treatment of an illness or injury. This could mean your annual well woman examination and pap smear would be your financial responsibility. If your health plan has determined that your annual preventive exam is not covered as a medical benefit on your plan, it will deny payment for this visit. Your plan may also not allow for discussion of problems on the same day as your preventive exam, and may deny payment for treatment of problems on this date.

As a patient and consumer we encourage you to contact your health plan to ensure that you understand what medical services are covered by your insurance. It is important to be specific when asking your insurance company if your annual examination is covered, and whether laboratory services are covered as well.

Co-payments are due at the time of your appointment. Please be prepared to make this payment when you arrive for your visit.

For our patients without insurance coverage (private pay), a \$100.00 pre-payment is due at the time of your appointment. Please contact our business office prior to your appointment to make arrangements for a payment plan if needed.

We would also like to remind you of our office policy that refills of narcotic prescriptions will only be authorized during regular office hours; Monday through Friday, 8:00 a.m. to 5:00 p.m.

**Some important Pap test information as you prepare for your annual exam.**

**For women without risk factors, our clinic follows the guidelines established by the American College for Colposcopy and Cervical Pathology.**

**Women aged 20 years and younger should not have a Pap test.**

**Women age 21 thru 29 should have a Pap test every three Years.**

**Women age 30 thru 64 should have a combination Pap with HPV test every five years.**

**Women age 65 and older do not need Pap smears unless they have a history of abnormal Pap tests.**

**Although you may not be due for a pap test, you do need an annual gynecologic exam.**

**Certain risk factors may influence the decision to do more frequent pap tests:**

Intercourse before age 16, more than 5 lifetime partners, infrequent pap tests, abnormal pap tests, a history of sexually transmitted infection, HPV, HIV, certain cancers, immunosuppression or exposure to DES.

If you have had a hysterectomy, speak to your provider about the need for continuing pap tests.

**What is a Pap test? What is the difference between a Pap test and an HPV DNA test?**

A Pap test is the standard way to see if there are any cell changes that you should be concerned about. The Pap test looks at a sample of cells from the cervix under a microscope to see if there are any abnormal cells. It is a very good test for finding not only cervical cancer cells but also cells that might become cancer cells. Usually health care providers do the Pap test as part of a pelvic exam. An HPV DNA test checks directly for high-risk HPV viruses. For both the Pap test and HPV DNA test, a small soft brush is used to collect cervical cells that are sent to a laboratory.

**What is HPV?**

HPV is short for human papillomavirus. An HPV infection is usually harmless and temporary: most people with HPV will never know they are infected because the virus usually goes away on its own. There are many types of this common virus, and only a few “high-risk” types can lead to cervical cancer. These high-risk HPV types are spread through sexual contact. There are also “low-risk” types of HPV that can cause genital or anal warts (and very rarely, oral warts), but do not cause cancer. HPV infection is very common in younger women. In most women under the age of 30, the virus will go away before it causes any significant cell changes or symptoms. If high-risk HPV types do not go away on their own, they may progress to abnormal precancerous cells. If these abnormal cells are not found and treated, they may become cancer over time. Most cell changes return to normal by themselves or simply die without progressing to cancerous lesions.

**Is the HPV DNA test covered by insurance?**

The screening HPV DNA test is usually covered by insurance. Please check with your own insurance company to see if the HPV DNA screening test is a covered expense for you once every three years. The CPT code for the screening HPV DNA test is 87621.

**OBGYN Confidential Health History Update**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Reason for visit (problems to be addressed): \_\_\_\_\_

**Marital Status:**  Single  Married  Partner  Divorced  Widowed

**Current Medications and Dosages:** Include Over-the-counter Meds & Supplements, refills needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergy updates** (medication, latex or severe food allergies): \_\_\_\_\_

**Refills needed** \_\_\_\_\_

**Habits:** Tobacco use: \_\_\_\_\_ Alcohol Use: \_\_\_\_\_ Recreational Drug Use: \_\_\_\_\_

**Cycle History:** Last period date: \_\_\_\_\_  Regular  Irregular  No Periods  Menopause

Number of days between periods \_\_\_\_\_ Length of period \_\_\_\_\_ Problems/Pain \_\_\_\_\_ Spotting \_\_\_\_\_

Quantity of flow:  Light  Moderate  Heavy Contraception: \_\_\_\_\_

**Sexual History:** Are you currently sexually active:  Yes  No

Number of current sexual partners \_\_\_\_\_ New sexual partners since your last visit?  Yes  No

**New medical diagnosis, surgery, serious illness or pregnancy since your last visit:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Change in family's medical history since your last visit:**

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Review of systems: Are you currently experiencing problems with:**

**General Well Being:**  Activity change  Appetite change  Fever/Chills  Fatigue  Weight changes

**Endocrine:**  Heat/Cold Intolerance  Thirst  Hair Loss/Growth  Hot flashes  Excessive sweating

**HENT:**  Facial swelling  Neck pain/stiffness  Ear discharge/pain, hearing loss/tinnitus  Nose

bleeds  Vision Loss, Discharge or Pain  Nose bleeds/Runny Nose/Congestion/ Post nasal drip,

Sneezing  Sinus Pressure  Dental Problems  Drooling  Sore mouth or throat  Trouble

swallowing  Voice changes

**Eyes:**  Discharge  Itching  Pain  Redness  Light sensitivity  Visual disturbances

**Respiratory:**  Apnea  Chest tightness  Choking  Cough  Shortness of Breath  Wheeze

**Cardiovascular:**  Chest Pain  Swelling of Lower Legs  Irregular Heartbeat (palpitations)

**Gastrointestinal:**  Abdominal Bloating  Anal bleeding  Blood in stool  Constipation  Diarrhea

Nausea  Rectal Pain  Vomiting  Reflux

**Genitourinary:**  Urinary Problems: Painful, frequent, sense of urgency, difficulty urinating, blood in urine

Urinary Incontinence  Flank pain  Genital sore  Pain or Bleeding with Intercourse

Vaginal Discharge, Odor, Itching or pain  Abnormal Vaginal Bleeding or Spotting  Breast Lumps,

Pain or Discharge  Concerns about sexual life or functioning

**Musculoskeletal:**  Back Pain  Joint Pain/swelling  Arthritis  Difficulty walking

**Skin:**  Color changes  Rash  Itching  Dryness  New Moles  Sores

**Neurological:**  Dizziness/Vertigo  Facial asymmetry  Headaches  Numbness  Seizures

Speech Difficulty  Fainting  Tremors  Weakness

**Hematology/Lymphatic:**  Severe Bruising  Easy Bruising  Enlarged Lymph Glands

**Psychiatric:**  Agitation/nervous/ anxious  Behavior problems  Confusion  Decrease concentration

Mood changes  Hallucinations  Hyperactive  Self injury  Insomnia  Suicidal ideations

**Allergic/Immunological:**  Seasonal Allergies  Persistent Infections

**Other** \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Health Maintenance:** Please date immunizations/tests/exams since your last visit:

Immunizations: Flu \_\_\_\_\_ Tetanus \_\_\_\_\_ TDAP \_\_\_\_\_ Pneumonia \_\_\_\_\_ HPV \_\_\_\_\_

Meningococcal \_\_\_\_\_ Rubella \_\_\_\_\_ MMR \_\_\_\_\_ Varicella \_\_\_\_\_ Shingles \_\_\_\_\_

Hepatitis A \_\_\_\_\_ B \_\_\_\_\_

STD Screening \_\_\_\_\_ HIV \_\_\_\_\_ GC/Chlamydia \_\_\_\_\_

Mammogram \_\_\_\_\_ Bone Density \_\_\_\_\_ Sigmoid/Colonoscopy \_\_\_\_\_

Cholesterol screen \_\_\_\_\_ Thyroid \_\_\_\_\_ Diabetes Screen \_\_\_\_\_

Eye Exam \_\_\_\_\_ Dental Exam \_\_\_\_\_ Skin Exam \_\_\_\_\_

Other information your provider should be aware of:

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**Please list in order of importance some concerns you would like to discuss:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Would you like an escort present during your exam?  Yes  No

Do you need paperwork filled out by your provider?  Yes  No

**Please bring these completed forms with you to your appointment.**

**OBGYN Health Center - 940 Royal Ave - Suite 350 - Medford OR - 97504-6193 Tele (541) 732-7460**