We would like to welcome you to Adena Women’s Health OB/GYN. We are thrilled you have chosen us for your healthcare needs. Our office provides a variety of services and delivers a high level of care from highly skilled physicians, midwives, and advanced practice providers.

The office is open Monday through Friday from 7:30 a.m. to 5 p.m. in Chillicothe and also provides services at five outlying sites including: Circleville, Greenfield, Jackson, Waverly and Washington Court House.

We have your appointment scheduled on ________________________ in ________________________ with ________________________________ at ________________________

Payments are required at time of service. This includes self-pay, co-payment and deductibles. If you are unable to pay at the time of service your appointment may be rescheduled. If you are unable to pay please let our office know prior to your appointment and we can help set you up with one of our financial aid counselors. Uninsured patients will be expected to pay $125.00 at the time of service for their first appointment.

We ask that you arrive 10 minutes prior to your appointment time to prevent delays to other patients, physicians and their own appointment times. We work to see as many patients a day as possible and it is imperative that you contact our office 24 hours in advance to cancel your appointment. We track all missed appointments.

There is a 10 minute window before a patient is considered “late.” This 10 minute window begins at the scheduled time and ends 10 minutes from that time. While we cannot guarantee a same day appointment our office will work to get you rescheduled. We realize that unforeseen circumstances can arise and those will need to be handled directly.

Chronic cancellations and/or no shows for scheduled appointments could result in a dismissal from our department. Any patient that “no-shows,” 3 times from this practice in a calendar year will be sent through the discharge process.

Any patient under the age of 18 must be accompanied by a legal guardian. Legal guardian means you can apply legal paper work stating you are responsible for the minor and consent for their treatment.

If you receive a patient satisfaction survey via email or US Postal office, we would appreciate your response to the care you received. Your opinion matters to us. Thank you for choosing us as your healthcare provider.

Wishing you the best of Health,
Adena Providers & Staff

Women’s Health OB/GYN | 740-779-7201
Women’s Health OB/GYN - Blackwater Road | 740-642-4400
We will make every effort to meet your expectations based on your individual healthcare needs. We are looking to establish long-term relationships with our patients and recommend taking advantage of our services allowing us to provide complete support for your women’s healthcare needs.

**SERVICES**

**These services include:**

- Obstetrics Care
- Labor and Delivery Unit
- Midwifery
- Lactation consultations
- Gynecologic surgery, including da Vinci® robotics
- Comprehensive prenatal care for mom and baby
- Menopause Management
- Wellness & Prevention Programs
- Same day appointments
- Dedicated women’s licensed independent social worker
- On-site lab for patient convenience
- Infertility

- On-site ultrasound at Adena Regional Medical Center, Waverly, Jackson, Washington Court House and Adena Ob/Gyn - Blackwater Road with registered sonographers
- Maternal Fetal Medicine (MFM) - Ohio State University travels to our office weekly for high-risk patients

So that we may better serve you, please arrive at least 15 minutes prior to your appointment time.

**Please bring the following with you to your upcoming appointment:**

1. Completed Health History Form of Past and Present Medical Condition
2. If applicable, completed Authorization for Release of Information
3. Your current insurance card and applicable payment for services (ie, copay, coinsurance, balance)
4. A state issued photo ID
5. Advanced Directive or Medical Durable Power of Attorney (if applicable)
6. Translator needs (if applicable - please call us 2 business days prior to appointment)
7. Email address so we can enroll you in patient portal for 24/7 access to your health information.
Have you been seen at our office in the past 3 years? Yes No

Previous Name: __________________________________________

Patient Name: __________________________________________ Date of Birth: ______________________________

First Day of Last Menstrual Cycle: ____________________________ Height: __________________________________

Current Medications (include dose and frequency)
________________________________________
________________________________________
________________________________________
________________________________________

Allergies and Reactions
____________________________________________
____________________________________________
____________________________________________
____________________________________________

Surgeries/Procedures/Hospitalizations (list dates)
________________________________________
________________________________________
________________________________________
________________________________________

Chronic Medical Problems/Conditions
____________________________________________
____________________________________________
____________________________________________
____________________________________________

GYN History
Age with first period: _______________________
Age of first intercourse: _____________________
Number of sexual partners: __________________
Current contraception: _____________________
Perform self-breast exams? ________________

Abnormal pap ( ) Yes ( ) No
Abnormal breast feedings ( ) Yes ( ) No
History of STDs ( ) Yes ( ) No
History of pelvic infections ( ) Yes ( ) No
Menopause? Date: _______ ( ) Yes ( ) No

Social History Yes No
Tobacco use: ( ) ( )
Alcohol use: ( ) ( )
Illicit drug use: ( ) ( )
Education level: __________
Occupation: ______________

Health Screening Yes Date No
Mammogram: ( ) _____ ( )
DEXA: ( ) _____ ( )
Colonoscopy: ( ) _____ ( )
Chlamydia screening: ( ) _____ ( )
Pap smear: ( ) _____ ( )

Vaccinations Yes Date No
Flu vaccine: ( ) _____ ( )
Gardasil: ( ) _____ ( )
Tetanus: ( ) _____ ( )
Pneumonia: ( ) _____ ( )
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<tr>
<th>OB History</th>
<th>Total number of pregnancies (circle #): 1 2 3 4 5 6 7 8</th>
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<tr>
<th>Child’s Name</th>
<th>Delivery Date</th>
<th>Weeks Gestation</th>
<th>Birth Weight</th>
<th>M/F</th>
<th>Vag/CS</th>
<th>Complications</th>
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History of miscarriage/demise? Yes No How many?___________ 1st 2nd 3rd trimester

Family History (please circle all that applies)

Mother: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________
Father: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________
Parental Grandmother: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________
Parental Grandfather: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________
Maternal Grandmother: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________
Maternal Grandfather: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________
Brother: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________
Sister: Alive/Deceased Diabetes Hypertension Heart Disease Mental Issues Cancer Type:___________

Cycles: How often do they occur?
Every 28 days Every month 20-25 days 35-40 days Not applicable Other___________

Martial Status
Single Married Divorced Separated Widow