Scott Kramer MD
Comprehensive, Contemporary, Compassionate Care for Women

Name _____ Age _____ Date of Birth _____

Primary Care Physician _____ Marital Status _____ Today's Date _____

How did you learn about us? _____ Email _____

Reason for seeing Doctor: ❑ Annual Exam Other: _____

I. GYN History:

DOCTOR'S COMMENTS

1. 1st day last menstrual period _____ ❑ Regular ❑ Irregular ❑ Heavy Bleeding
2. What are you using to prevent pregnancy, if needed? None
3. When was your last PAP smear? _____
4. Have you ever had an abnormal PAP smear? ❑ Yes ❑ No When?
5. When was your last Mammogram *(recommended after 40)*? _____
6. If you are menopausal, are you taking hormones? ❑ Yes ❑ No
7. Do you experience urine leakage? ❑ Yes ❑ No

II. Pregnancy History:
(please list the number)

Times Pregnant 0

Term Births 0 Premature Births _____ Miscarriages _____ Abortions _____ Living Children _____

#	Born (Year)	Type of Delivery	Complications
1			
2			
3			
4			
5			

IV. Medical History:

Do you have any medical illnesses? *(please list)* ❑ None

_____ _____

_____ _____

_____ _____

_____ _____

Medications: *(please list name & dose)* ❑ None

_____ _____

_____ _____

_____ _____

_____ _____

What medications are you allergic or had a reaction? ❑ None

_____ _____

_____ _____

V. Surgical & Hospitalization History: ❑ None

Date (Year)	Operation or Illness	Complications Yes	No
		❑	❑
		❑	❑
		❑	❑
		❑	❑
		❑	❑

(over →)

V. Family History:

Please click on this link now to complete your family's cancer history online:

https://www.mygenehistory.com/skramermdathome

VI. Social History:

1. What is your occupation? _____

	Yes	No
2. Do you currently smoke?	❑	❑
2a. # cigarettes per day _____		
3. Do you drink Alcohol > 2 drinks per day?	❑	❑
4. Have you used recreational drugs in the past 5 years?	❑	❑
5. Has anyone threatened or hurt you in the last year?	❑	❑

VII. Sexual History: (Important to help us customize your care and screening tests)

1. # of sexual partners in the past year? Male _____ Female _____
   ☐ Vaginal Sex ☐ Oral Sex (recieving) ☐ Oral Sex (giving) ☐ Anal ☐ Decline

	Yes	No
2. Have you ever had any sexually transmitted diseases (check)? ☐Herpes ☐Gonorrhea ☐ Chlamydia ☐Genital Warts ☐HIV	❑	❑
3. Do you have any concerns about your sex life that you wish to discuss?	❑	❑

VIII. Dietary & Exercise History:

1. How many servings of dairy products do you eat in an average day? _____

	Yes	No
2. Are you currently dieting?	❑	❑
3. Do you exercise regularly?	❑	❑
Type(s) _____		

IX. Pharmacy: _____ Street _____ City _____

For Doctor's Use

Physical Exam:

Height ___ft ___in Weight _____lbs BMI_____ BP _____/_____ HgB _____ Preg Test _____ Temp _____

Breasts: ❑ nl
Abd: ❑ nl
Ext: ❑ nl
Vag: ❑ nl
Cx: ❑ nl
Ut: ❑ nl
Adnx: ❑ nl

A/P:

Orders:
❑ Pap ❑HPV
❑ GC/Chl
❑ Mammo
❑ BMD
❑Pelvic Sono

Counseling:
❑ Menopause
❑ Calcium
❑ Kegel's
❑ HRT
❑Hemorrhoids

❑ Birth Control
❑ Folate/Preconc.
❑ Smoking
❑ Safer Sex
❑Weight Loss

Clinician _____

Cancer Family History Questionnaire

Please complete your family's cancer history online, then skip this page

PERSONAL INFORMATION

Patient Name	Date of Birth	Age

Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider
F		Scott Kramer MD

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU Age of Diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of Diagnosis	RELATIVES on your MOTHER'S SIDE	Age of Diagnosis	RELATIVES on your FATHER'S SIDE	Age of Diagnosis
☒ Y ☐ N	***Example: Breast Cancer***	***45***	***------***	***------***	***Aunt Cousin***	***45 61***	***Grandmother***	***53***
☐ Y ☐ N	Breast cancer *(Female or Male)*							
☐ Y ☐ N	Ovarian cancer *(Peritoneal/Fallopian tube)*							
☐ Y ☐ N	Endometrial (*Uterine*) cancer							
☐ Y ☐ N	Colon/rectal cancer							
☐ Y ☐ N	10 or more Lifetime Colon/ Rectal Polyps *(Specify #)*							
☐ Y ☐ N	Pancreatic cancer							
☐ Y ☐ N	Prostate cancer	N/A						
☐ Y ☐ N	Other Cancer(s) *(Specify cancer type)*	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate						
☐ Y ☐ N	Are you of Ashkenazi Jewish descent?							
☐ Y ☐ N	Are you concerned about your personal and/or family history of cancer?							
☐ Y ☐ N	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible) If Yes, Who? _____ What gene(s)? _____ What was the result? _____							

BREAST CANCER RISK MODEL INFORMATION

Your current height (ft/in) ___-___ **Your current weight** (lbs) _____

Your menopausal status:

- ☐ Pre-menopausal
- ☐ Peri-menopausal (time before menopause marked by irregular cycles)
- ☐ Post-menopausal: Age of onset _____
  (permanent cessation of period for 12 months or longer)

Your age at time of first menstrual period _____

Have you had a live birth? ☐ No ☐ Yes: **age at time of first live birth** _____

Did you ever use Hormone Replacement Therapy? ☐ Yes ☑ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ unknown

If yes, are you a: ☐ Current user: How many years ago did you start? _____
Intend to use for _____ more years

☐ Past user: How many years ago did you stop using? _____

Have you ever had a breast biopsy? ☐ Yes ☑ No

If yes, do you know your diagnosis? _____

Number of daughters _____ **Number of sisters** _____

Number of maternal aunts (mother's sisters) _____

Number of paternal aunts (father's sisters) _____

HEREDITARY CANCER RED FLAGS (complete with your healthcare provider)

Personal and/or family history of any one of the following
(check all that apply):

MULTIPLE: A combination of cancers on the same side of the family:
- ☐ **2 or more:** breast / ovarian / prostate / pancreatic cancer
- ☐ **2 or more:** colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)
- ☐ **2 or more:** melanoma / pancreatic

YOUNG: Any 1 of the following at age **50 or younger:**
☐ Breast cancer ☐ Colon/rectal cancer ☐ Endometrial cancer

RARE: Any 1 of these rare presentations at **any age:**
- ☐ Ovarian cancer (Peritoneal/Fallopian tube)
- ☐ Breast: Male breast cancer or Triple negative breast cancer (ER-, PR-, HER2- Pathology)
- ☐ Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology††
- ☐ Endometrial cancer with abnormal MSI/IHC
- ☐ 10 or more colon/rectal polyps*

Certain ancestries such as Ashkenazi Jewish, may have greater risk for hereditary cancer syndromes

*††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type*
Assessment criteria based on medical society guidelines. For medical society guidelines, go to MyriadPro.com

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature	Date
Health Care Provider's Signature *Scott Kramer MD*	Date

Office Use Only

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If yes and accepted, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update

☐ Other: _____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received a copy of the Privacy Practices for California Cardiovascular Consultants

I hereby give my consent for California Cardiovascular Consultants to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The physicians reserve the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: The Privacy Official at *a33* Mowry Ave, Ste 30 Fremont, CA *94538.*

With this consent, the physicians or office staff may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory results among others.

With this consent the physicians may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that the physicians restrict how they use or disclose my PHIl to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if if does, it is bound by this agreement. By signing this form, I am consenting to the physician's use and disclosure of my PM to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. III do not sign this consent, or later revoke it, the physicians may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient’s Name Date

_____

Print Name of Patient or Legal Guardian

CCCMA INFORMATION RECORD

Physicians Name for Today's Appointment: Dr. Scott Kramer

Referred By: _____ Today's Date: _____

PLEASE PRINT CLEARLY

PATIENT

Last Name	First Name	Middle	Sex	Home Phone #	
			Female	Cell Phone #	
Address		Apt #	City	State	CA
				Zip	
Birth Date	Social Security #	Drivers License #		Email	
				Marital Status	
Employer	Address	Apt #	City	State	Zip
				CA	
Occupation	Work Phone #	Emergency Contact NOT living w/ you		Relationship	
Emergency Contact Phone	Ethnicity/Race	Person Responsible for the Bill			
	Caucasian				

SPOUSE

Last Name	First Name	Middle	Sex	Occupation	Work Phone #
				Birth Date ____/____/____	Cell Phone #

INSURANCE

Primary Insurance Company Name	Primary Insurance ID #	Secondary Insurance Company Name	Second Insurance ID #

Preferred Language

☐ English ☐ Vietnamese ☐ Tagalog ☐ Russian
☐ Burmese ☐ Cantonese ☐ Mandarin ☐ Korean
☐ Farsi ☐ Spanish ☐ Armenian ☐ Others/Specify

Interpreter Needed?

☐ Yes (Accepted) ☑ No (Declined)

If Yes, note date ____/____/____

If No, note date ____/____/____

Hearing impaired? ☐ Yes ☑ No
(ASL) Interpreter? ☐ Yes ☑ No
If No, note date ____/____/____

If member is a minor, identify decision maker:

☐ Mother ☐ Father ☐ Legal Guardian ☐ Self (emancipated minor)

Name: _____

Address: _____ City: _____ State: CA Zip: _____

Phone #: (_____)_____-_____ Cell: (_____) _____-_____

Do you have an Advanced Healthcare Directive (patients 18 years and over) [ ] Yes [✓] No

****Power of attorney agreement listing instructions about your healthcare wishes.**
If you do not have an Advanced Healthcare Directive, would you like a copy as an example to refer to? [ ] Yes [✓] No

1. **I understand that I am financially responsible for all charges not covered by my insurance company.**
2. **I authorize release of any information to the Insurance Company.**
3. **I authorize direct payment of any and all insurance benefits to my doctor.**
4. **All the above information is correct.**

Signature of Patient or Legal Guardian _____ DATE _____/_____/_____

FINANCIAL RESPONSIBILITY WAIVER

PATIENTS WITH INSURANCE: Although we will bill your insurance company/ Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan/Medical Group, we will contact you for assistance. Should your health plan/Medical Group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

DUAL COVERAGE: abides by the California State insurance laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary and tertiary health plans.

PATIENTS WITHOUT INSURANCE: Our fees cannot always be determined in advance, since they depend on services rendered. You will, therefore, be quoted a deposit amount, which must be paid at the time of service. Any charge over the deposit amount will be billed to you and will be due in full within thirty (30) days from the date of your billing statement. Please make payment arrangements for costly services in the Credit Department.

RETURNED CHECKS: There is a $20.00 service fee for returned checks.

COPAY POLICY: Your health plan requires that you make your copay at the time of visit. However, in an emergency situation when you are unable to make your copayment, you will be granted a 10 day grace period in which to make payment without penalty.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any medical information which may have a bearing on the determination and/or payment of my claim. I request that payment be made directly to _CCCMA_____, and I acknowledge that I am responsible for payment if this assignment is not honored.

EMPLOYMENT AND CREDIT VERIFICATION: I authorize_CCCMA__ to contact my employer for employment and/or benefit verification and to request a credit report when deemed necessary.

I have read and understand the above policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

_____ _____

Patient Signature **Date**

I/we wish to accept financial responsibility for medical expenses incurred by the above named patient.

_____ _____

Guarantor Signature **Date**

ELIGIBILITY GUARANTEE FORM

PATIENTS NAME/NOMBRE DEL PACIENTE **EFFECTIVE DATE/FECHA EFECTIVA**

PATIENTS DATE OF BIRTH/FECHA DE NAIMIENTO DEL PACIENTE **PATIENTS ID # / NUMERO DE IDENTIFICACION**

NAME IF INSURED, IF DIFFERENT/NOMBRE DEL ASEGURAD, SI DIFERENTE **RELATIONSHIP TO PATIENT/RELACION AL PACIENTE**

Patient

INSURANCE (HMO) / SEGURO (HMO) **EMPLOYER OR GROUP/LUGAR DE TRABAJO OR GRUPO** **ID#**

PRIMARY CARE PROVIDER/NOMBE DEL DOCTOR

I, the above named palient, hereby certify that the information stated above is true, to the best of my knowledge.

I understand and agree that if I am not eligible, I am responsible for all charges incurred for services rendered.

Yo, el paciente nombrado(a) arriba, declaro que Ia informacion proporcionada es correcta y verdadera:

Entiendo y estoy de acuerdo que si no soy elegible, soy responsable por todos los gastos iricurridos.

_____ _____

Signature of Patient / Firma del Paciente **Date / Fecha**

_____ _____

Signature of Insured / Firma del Asegurado **Date / Fecha**

_____

Name of contact person in PCP's office

Scott Kramer MD
Comprehensive, Contemporary, Compassionate Care for Women

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION AS REQUIRED BY HIPAA PRIVACY RULES

_____ _____
Name of Patient (Print) Birth Date

CA

_____
Street Address City State Zip

_(_____)_____
Cell or Daytime Phone Number

Authorizes Release of Protected Health Information—From:

_____
_____
_____

To:
Scott Kramer MD
2333 Mowry Ave., Suite 201
Fremont, CA 94538

FAX Medical Records to (888) 811-0578

Information To Be Released:

✓ Medical Records (past 3 years inclusive of health care summary, clinic notes, labs, imaging studies, consultant's notes; past 10 years for pathology reports, hospital & operative records)

Other: _____

Purpose For Need Of Disclosure:
Continuation of Medical Care

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:
Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the medical records department of the Washington Township Medical Foundation. **Right to Receive copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the medical records department of Washington Township Medical Foundation. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative:_____ **Date:**_____
(If signed by other than patient, state relationship and authority to do so.)

Patients please fax completed form to (510) 796-7760 or mail to office

CLEAR FORMS Email Forms PRINT FORMS