GENERAL INFORMATION

Dr. Naylor and Dr. Lloyd will try to see you at your appointment time. However, due to the unpredictable nature of their practice, unexpected emergencies can occur. We can not assume responsibility for lost time due to a prolonged wait. You may feel free to reschedule if such a situation occurs.

Effective August 10, 2004, a fee will be assessed for new and established patients who fail to show up for their appointment, or cancel without twenty-four hours notice.

Our office will be happy to assist you with any medical record or FMLA needs. We will require a HIPAA compliant release form. Please allow up to 72 hours to complete, and return, all requested forms and records. Please see the front desk for any requests, or contact us at (801) 263-8511.

A $25.00 handling fee will be applied to all returned checks. Our office is equipped to take cash, check, money order, Visa, Mastercard, and Discovercard.

Dr.'s Naylor and Lloyd operate out of St. Mark's Hospital, Intermountain Medical Center, and St. Mark's Outpatient Surgical Center. Both doctors want you to know that they have a financial interest in St. Mark's Outpatient Surgical Center, but the choice of where you have your surgery is yours. You may elect to have your surgery at another previously listed facility if you so desire.

Thank you for your assistance and compliance. Please see the front desk, or feel free to call (801) 263-8511, with any concerns or questions.

______________________________ ______________________________

Patient Name Signature

____

Date

R.G Naylor Surgical Inc. (Dr.'s Naylor and Lloyd)
NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003

OUR PRIVACY RESPONSIBILITIES
R.G. NAYLOR SURGICAL INC. IS REQUIRED BY LAW TO:
*MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION
*PROVIDE THIS NOTICE THAT DESCRIBES THE WAYS WE MAY USE AND SHARE YOUR HEATH INFORMATION; AND
*FOLLOW THE TERMS OF THE NOTICE CURRENTLY IN EFFECT.

WE RESERVE THE RIGHT TO MAKE CHANGES TO THIS NOTICE AT ANY TIME AND MAKE THE NEW PRIVACY PRACTICES EFFECTIVE FOR ALL INFORMATION WE MAINTAIN. CURRENT NOTICES WILL BE POSTED IN OUR OFFICE. YOU MAY ALSO REQUEST A COPY OF ANY NOTICE.

Your Individual Rights
YOU HAVE THE RIGHT TO:
*REQUEST RESTRICTIONS ON HOW WE USE AND SHARE YOUR HEALTH INFORMATION. WE WILL CONSIDER ALL REQUESTS FOR RESTRICTIONS CAREFULLY BUT ARE NOT REQUIRED TO AGREE TO ANY RESTRICTION;
*REQUEST THAT WE USE A SPECIFIC TELEPHONE NUMBER OR ADDRESS TO COMMUNICATE WITH YOU;
*REQUEST TO INSPECT AND COPY YOUR HEALTH INFORMATION, INCLUDING MEDICAL AND BILLING RECORDS. FEES MAY APPLY. UNDER LIMITED CIRCUMSTANCES, WE MAY DENY YOU ACCESS TO A PORTION OF YOUR HEALTH INFORMATION AND YOU MAY REQUEST A REVIEW OF THE DENIAL;
* REQUEST CORRECTIONS OR ADDITIONS TO YOUR HEALTH INFORMATION;
* REQUEST AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR HEALTH INFORMATION MADE BY US. THE ACCOUNTING DOES NOT INCLUDE DISCLOSURES MADE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS AND SOME DISCLOSURES REQUIRED BY LAW. YOUR REQUEST MUST STATE THE PERIOD OF TIME DESIRED FOR THE ACCOUNTING, WHICH MUST BE WITHIN THE SIX YEARS PRIOR TO YOUR REQUEST AND EXCLUDE DATES PRIOR TO APRIL 14, 2003. THE FIRST ACCOUNTING IS FREE BUT A FEE WILL APPLY IF MORE THAN ONE REQUEST IS MADE IN A 12-MONTH PERIOD; AND
* REQUEST A PAPER COPY OF THIS NOTICE EVEN IF YOU AGREE TO RECEIVE IT ELECTRONICALLY.
** ALL REQUEST MUST BE IN WRITING**

How We Use Your Health Information
WHEN YOU RECEIVE CARE, WE MAY USE YOUR HEALTH INFORMATION FOR TREATING YOU, BILLING FOR SERVICES, AND CONDUCTING OUR NORMAL BUSINESS KNOWN AS HEALTH CARE OPERATIONS. EXAMPLES OF HOW WE USE YOUR INFORMATION INCLUDE:

***TREATMENT**- WE KEEP RECORDS OF THE CARE AND SERVICES PROVIDED TO YOU. WE MAY SHARE YOUR HEALTH INFORMATION WITH A SPECIALIST WHO WILL ASSIST IN YOUR TREATMENT. SOME HEALTH RECORDS, INCLUDING SOME CONFIDENTIAL COMMUNICATIONS WITH A MENTAL HEALTH PROFESSIONAL AND SOME SUBSTANCE ABUSE RECORDS, MAY HAVE ADDITIONAL RESTRICTIONS ON THE USE AND DISCLOSURE UNDER STATE AND FEDERAL LAWS.

***PAYMENT**- WE KEEP BILLING RECORDS THAT INCLUDE PAYMENT INFORMATION AND DOCUMENTATION OF THE SERVICES PROVIDED TO YOU. YOUR INFORMATION MAY BE USED TO OBTAIN PAYMENT FROM YOU, YOUR INSURANCE COMPANY, OR OTHER THIRD PARTY. WE MAY ALSO CONTACT YOUR INSURANCE COMPANY TO VERIFY COVERAGE FOR YOUR CARE OR TO NOTIFY THEM OF UPCOMING SERVICES THAT MAY NEED PRIOR NOTICE OR APPROVAL. FOR EXAMPLE, WE MAY DISCLOSE INFORMATION ABOUT YOU TO CLAIM AND OBTAIN PAYMENT FROM YOUR INSURANCE COMPANY OR MEDICARE/

***HEALTH CARE OPERATIONS**- WE USE HEALTH INFORMATION TO IMPROVE OUR QUALITY OF CARE, TRAIN STAFF, PROVIDE CUSTOMER SERVICE, MANAGE COSTS, AND CONDUCT REQUIRED BUSINESS DUTIES.

Other Services We Provide
WE MAY ALSO USE YOUR HEALTH INFORMATION TO:
*RECOMMEND TREATMENT ALTERNATIVES;
*TELL YOU ABOUT HEALTH SERVICES AND PRODUCTS
*SHARE INFORMATION WITH FAMILY OR FRIENDS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE WHEN APPROPRIATE;
* SHARE INFORMATION WITH THIRD PARTIES WHO ASSIST US WITH TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. OUR BUSINESS ASSOCIATES MUST PROTECT YOUR INFORMATION BY FOLLOWING OUR PRIVACY PRACTICES;
* REMIND YOU OF AN APPOINTMENT (IF YOU DO NOT WISH TO BE REMINDED, NOTIFY THE SCHEDULER).

Sharing Your Health Information

THERE ARE LIMITED SITUATIONS WHEN WE ARE PERMITTED OR REQUIRED TO DISCLOSE HEALTH INFORMATION WITHOUT YOU SIGNED AUTHORIZATION. THESE SITUATIONS ARE:

*FOR PUBLIC HEALTH PURPOSES SUCH AS COMMUNICABLE DISEASES, WORK RELATED ILLNESSES, OR OTHER DISEASES AND INJURIES PERMITTED BY LAW; REPORTING BIRTHS AND DEATHS; AND REPORTING REACTIONS TO DRUGS AND PROBLEMS WITH MEDICAL DEVICES;
* TO PROTECT VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE;
*FOR LAWSUITS AND SIMILAR PROCEEDINGS;
* WHEN OTHERWISE REQUIRED BY LAW;
* WHEN REQUESTED BY LAW ENFORCEMENT AS REQUIRED BY LAW COURT ORDER;
* TO CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS;
* FOR ORGAN AND TISSUE DONATION;
*TO REDUCE OR PREVENT A SERIOUS THREAT TO PUBLIC HEALTH AND SAFETY;
* FOR WORKERS' COMPENSATION OR OTHER SIMILAR PROGRAMS IF YOU ARE INJURED AT WORK; AND
* FOR SPECIALIZED GOVERNMENT FUNCTIONS SUCH AS INTELLIGENCE AND NATIONAL SECURITY.

ALL OTHER USES AND DISCLOSURES, NOT DESCRIBED IN THIS NOTICE, REQUIRE YOUR SIGNED AUTHORIZATION. YOU MAY REVOKE YOUR AUTHORIZATION AT ANY TIME WITH A WRITTEN STATEMENT.

PATIENT SIGNATURE DATE

WRITTEN EXPLANATION OF ARBITRATION

A binding arbitration agreement requires a patient to submit all future medical malpractice claims to arbitration instead of having those claims heard in a court by a judge or jury.

An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. A panel of three arbitrators will hear the information presented by both sides and then render a final decision. You select an arbitrator, your doctor selects an arbitrator, and you and the doctor agree on a third arbitrator. In the event we cannot agree, the third arbitrator will be selected by the other two arbitrators from a court-issued list of arbitrators. You and your doctor may also agree that the dispute be heard by only one arbitrator.

You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator, and the fees and expenses of the third arbitrator are shared equally. Should the parties agree that only one arbitrator be selected, the parties will equally share the fees and expenses of the arbitrator.

You have the right, at your expense, to be represented in arbitration by an attorney.

By choosing arbitration, you also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.

Whether you sign the arbitration agreement or not is up to you. You will not be treated any differently if you choose not to sign the agreement.

You have the right to rescind the agreement within ten (10) days of signing the agreement.

The arbitration agreement is automatically renewed each year unless it has been cancelled in writing before the renewal date.

You have the right to have all of your questions about arbitration answered.

I have read and understand the foregoing Written Explanation of Arbitration. I have been verbally encouraged to read the Arbitration Agreement and the Written Explanation of Arbitration and to ask any questions. I have had the opportunity to ask questions and have my questions answered.

____

Name of Patient (Print)

____ ____________________

Signature of Patient or Patient's Representative Date (MM/DD/YYYY)

ARBITRATION AGREEMENT

Article 1 - Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury, except to enforce our decision to arbitrate, to collect any arbitration award, and to facilitate the arbitration process as permitted by the Utah Arbitration Act.

Article 2 - Definitions

A. The term "we," "parties," or "us" means you (the Patient) and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code § 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group, or clinic and their employees, partners, associates, agents, successors, and estates.

D. The term "Patient" or "you" means:

(1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents, or legal representatives, AND

(2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 - Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:

(1) working directly with each other to try and find a solution that resolves the Claim, OR

(2) using non-binding mediation (each of us will bear one-half of the costs); OR

(3) using binding arbitration as described in this Agreement. You may choose to use any or all of these methods to resolve your Claim. You also have the right to require mediation of your Claim prior to the arbitration of your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process but each of us will pay the fees and costs of our own attorney,

C. Arbitration - Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We agree that the decision reached in binding arbitration will be final.

Article 4 - How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, you must mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim, including the date of the claimed occurrence, the complained of conduct by the Physician, and a description of the Patient's injuries and damages (the "Notice"). If the Notice is sent to the Provider by certified mail, it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement. We agree that a notice of intent to commence action, as provided by Utah Code § 78B-3-412, shall not constitute the required Notice under this Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

(I) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act, including the authority to establish scheduling orders; supervise the conduct of discovery; prevent abuse and ensure efficiency and cost-effectiveness; rule on all motions, including motions for summary judgment and motions to dismiss for failure to proceed with reasonable diligence; administer oaths; and issue subpoenas.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act,

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding

("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A Joined Party does not participate in the selection of the arbitrators but is considered a Provider for all other purposes of this Agreement.

Article 5 - Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 - Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in the county of the Physician's principal place of business. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved unless the parties otherwise agree. The provisions of the Utah Uniform Arbitration Act, the Utah Health Care Malpractice Act (with the exception of the notice of intent and prelitigation hearing requirements), and the Federal Arbitration Act govern this Agreement. The parties hereby waive the requirement of Utah Code § 78B-3-416 to appear before a hearing panel in a malpractice action against a health care provider. The comparative fault provisions of Utah law apply to the arbitration, and the arbitrators shall apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 - Term / Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 - Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

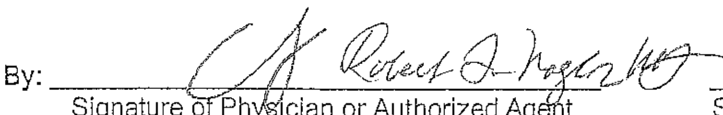
Article 9 - Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have been verbally encouraged to read the terms of this agreement and to ask any questions. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having it heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration-related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 - Receipt of Copy I have received a copy of this document.

ROBERT G. NAYLOR SURGICAL INC.
Provider (Name of Physician, Group, or Clinic)

Name of Patient (Print)

By: 
Signature of Physician or Authorized Agent
Representative (Date) Rev 08/09

Signature of Patient or Patient's

Updated 11/15/2011

PATIENT INFORMATION (Print)
Robert G. Naylor, M.D. / Erika C. Lloyd, M.D.

Referred to this office by:______________________________ Today's Date:______________
Full Name:______________________________ Sex: M F Marital Status: M S D W
Address:______________________________ City:______________ State:______ Zip:__________
Date of Birth:__________________ Age:__________ Social Security Number:__________________
Cell Phone:__________________ Home Phone:__________________ Work Phone:__________________
E-Mail Address:______________________________ Employer Name:______________________________
Employer Address:______________________________ City:______________ State:______ Zip:__________
Emergency Contact:______________________ Relationship:______________ Phone:______________
Spouse's Name:______________________

GUARANTOR INFORMATION (Policyholder of Insurance)

Guarantor Name:______________________________ Relationship to Patient:______________________
Address(If different):______________________________ City:______________ State:______ Zip:__________
Date of Birth(**required**):__________________ Age:______ Sex: M F SSN:__________________
Phone:__________________ Employer:______________________ Work Phone:______________

INSURANCE INFORMATION

Primary Insurance Company:______________________________ Guarantor:______________________
Ins. Address:______________________________ City:______________ State:______ Zip:__________
ID/Claim Number:______________________ Group Number:______________ Eff. Date:__________
Contact:______________________________ Contact's Phone Number:______________________
Secondary Insurance Company:______________________________ Guarantor:______________________
Ins. Address:______________________________ City:______________ State:______ Zip:__________
ID/Claim Number:______________________ Group Number:______________ Eff. Date:__________
Contact:______________________________ Contact's Phone Number:______________________

AUTHORIZATION / FINANCIAL RESPONSIBILITY AGREEMENT

I hereby authorize Dr. Naylor and/or Dr. Lloyd to furnish my insurance carrier with all the information concerning my illness, injury, and/or medical care. I also authorize benefits to be paid directly to Dr. Naylor and/or Dr. Lloyd. I accept full financial responsibility for all services provided to me and/or my family. In the event any balance remains unpaid for a period of 90 days, I understand that I will be charged a monthly billing fee of $10.00 per month. If my account is referred to a collection agency or attorney, I agree to pay all collection fees, court costs, and/or legal fees beginning at 35% of the past due balance. I have fully read and understand the agreement above.

Signature:______________________________________ **Date:**____________________

NEW PATIENT HISTORY FORM

Full Name:______________________________ Today's Date:______________________
Date of Birth:________________ Age:______ Sex: M F Marital Status: M S D W
Occupation:________________________ Height:__________ Weight(**required**):__________

The reason for your visit today: ____
____
____

Medication Allergies: ____
Present Medications: ____
____

Family History

Father:	Alive____	Deceased____	Cause:____________
Mother:	Alive____	Deceased____	Cause:____________
Siblings:	#Alive____	# Deceased____	Cause:____________
	Total #:____		

Do you have a family history of:

1. Heart Disease	Yes	No
2. High Blood Pressure	Yes	No
3. Diabetes	Yes	No
4. Stroke	Yes	No
5. Cancer	Yes	No
6. Thyroid Disease	Yes	No

Review of Your Body Systems: Do you have now, or have you ever had, any of the following?

	No	Yes	Please Explain
1. Ulcers	___	___	
2. Colitis	___	___	
3. Rectal Bleeding	___	___	
4. Change in Bowel Habits	___	___	
5. Black Tarry Stools	___	___	
6. Heart Disease	___	___	
7. High Blood Pressure	___	___	
8. Chest Pain	___	___	
9. Coughing Blood	___	___	
10. Shortness of Breath	___	___	
11. Thyroid Disease	___	___	
12. Lung Disease	___	___	
13. Cancer (location)	___	___	
14. Asthma or Emphysema	___	___	
15. Hepatitis (jaundice/liver disease)	___	___	
16. Gallbladder Disease	___	___	
17. Venereal Disease	___	___	
18. Kidney Stones	___	___	
19. Blood in Urine	___	___	
20. Epilepsy	___	___	
21. Swollen or Painful Joints	___	___	
22. Nervous Disorder	___	___	
23. Depression	___	___	
24. Diabetes	___	___	
25. Stroke	___	___	
26. Back Disorder	___	___	
27. Blood Disease/Anemia	___	___	

Full Name:____________________ Date of Birth:____________________

Personal History

Hospitalizations

		Year	Hospital
Illnesses (Kind)	______	____	____________
	______	____	____________
	______	____	____________
Surgeries (Kind)	______	____	____________
	______	____	____________
	______	____	____________

Your Children

Number Living:____ Diseases in Children:____________________

Number Deceased:____ Cause:____________________

Your Personal Habits

	No	Yes	Please Explain
Do you exercise regularly? (3-4 times/wk)	___	___	____________
Do you wear your seat belt? (90% of the time)	___	___	____________
Do you use illegal drugs? If so, what kind?	___	___	____________
Do you drink alcohol? If so, how many drinks per week?	___	___	____________
Were you ever a heavy drinker?	___	___	____________
Do you smoke? If so, how often?	___	___	____________

If ever, when did you stop? ____________

Tests and Immunizations (Give date last done)

	Yes	Year Performed	Not Sure	Comments
Pap Smear	___	______	___	____________
Breast Exam	___	______	___	____________
Mammogram	___	______	___	____________
Rectal Exam	___	______	___	____________
Sodium and Potassium	___	______	___	____________
Colonoscopy	___	______	___	____________
Stool Occult Blood	___	______	___	____________
Chest X-Ray	___	______	___	____________
EKG	___	______	___	____________
Cholesterol/Triglycerides	___	______	___	____________
CBC (Blood Test)	___	______	___	____________
Fasting Blood Sugar	___	______	___	____________
Thyroid Profile	___	______	___	____________
Tetanus (DPT)	___	______	___	____________
Flu Shot	___	______	___	____________
Pneumonia Vaccine	___	______	___	____________
Hearing Test	___	______	___	____________
Vision Test	___	______	___	____________
Genitalia Exam (Male)	___	______	___	____________
Treadmill Stress Test	___	______	___	____________
Blood Profile	___	______	___	____________
Pulmonary Function	___	______	___	____________
Urinalysis	___	______	___	____________

Women Only

Menstrual Periods: Age of onset:____ (Circle one) Regular Irregular

Date of last period:__________ Difficulties with periods:__________

Pregnancies: Number of: Born alive:____ Cesarean sections:____ Miscarriages:____

Premature:____ Stillborn:____

Describe any complications:____________________