PROVIDENCE
Medical Group
OB-Gyn Health Center

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Welcome to Providence Medical Group-OB/GYN Health Center.

Dear Patient,

We look forward to seeing you in our clinic for your ongoing women's health care. Please review this information to be sure we have scheduled you for the appropriate visit that will meet your medical needs under Medicare.

According to Medicare guidelines, any concerns that are not gynecologic in nature need to be addressed with your primary care provider. If you are at high risk for cancer, Medicare will cover a pelvic exam and breast exam every 12 months. Please see insert or visit www.medicare.gov for complete information.

Please make sure that there is an interval of 24 months plus one day since your last pelvic and breast exam, (unless you are at high risk). If you need to discuss gynecology-related issues, please call our office and let the scheduler know so that an appointment of appropriate length may be scheduled. Please remember that your PCP must address all non gynecology-related issues.

If you have further questions, please call our office at 541-732-7460.

Medicare Breast, Pelvic,Mammogram and Bone Density Screening FAQs

Cervical and vaginal cancer screening (Pap test and pelvic exam)
Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare covers a clinical breast exam to check for breast cancer.

How often is it covered?
Medicare covers a Pap test and pelvic exam once every 24 months. However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.

For whom?
All women who are insured by Medicare.

Your costs in the original Medicare plan?
You pay nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, you pay 20 percent of the Medicare-approved amount with no Part B deductible.

What factors increase risk for cervical cancer?
Your risk for cervical cancer increases if you:

- Have had an abnormal Pap test
- Have had cancer in the past
- Have been infected with the human papillomavirus (HPV)
- Began having sex before age 16
- Have had many sexual partners
- Have a diet that is low in fruits and vegetables
- Are overweight or obese
- Had many full term pregnancies
- If your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you

Breast cancer screening mammograms

Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the United States. Every woman is at risk, and the risk increases with age. Breast cancer is often successfully treated when found early. Medicare covers screening mammograms and digital technologies for screening mammograms to check for breast cancer before you or a doctor may be able to feel it.

How often is it covered?
Once every 12 months.

For whom?
All women insured by Medicare, age 40 and older can get a screening mammogram every 12 months. Medicare also pays for one baseline mammogram for women covered by Medicare, between the ages of 35 and 39.

Your costs in the original Medicare plan?
You pay 20 percent of the Medicare-approved amount with no Part B deductible.

What factors increase risk for breast cancer?
Your risk of developing breast cancer increases if you:

- Had breast cancer in the past
- Have a family history of breast cancer (mother, sister, daughter, or two or more close relatives who have had breast cancer)
- Had your first baby after age 30
- Have never had a baby
- Used hormone replacement therapy for a long period of time after menopause
- Have two or more alcoholic drinks every day
- Are overweight or obese, especially if you gained weight during adulthood
- Don't exercise
- Are of eastern European Jewish descent (Ashkenazi)

Risk for breast cancer increases with age. It is important to continue with screening, even if you were screened before you entered Medicare.

Providence Medical Group-OB/GYN Health Center confidential health history

Please fill out these forms and bring them with you to your appointment.

Name: ____Date: ________________

Date of birth: _________ Age: ______ Referring doctor: _______________________

Occupation: _________________
Marital/relationship status: _________________How long? ______

How did you hear about us? Website/Internet__ Yellow Pages __
Postcard/mailer__
Friend/family member (name) _________________________ Other
____

Reason for visit: (problems to be addressed)

____
____
____
____

Current medications: (Prescriptions, over-the-counter medications, supplements and vitamins)

____
____
____
____

Tobacco use and history:

____

Alcohol Use: ________________________Recreational Drug Use: ______________

Allergies: (medication, latex, or severe food allergies)

____

Cycle history: Last period date: _______________ Regular__ Irregular __ No __
Periods___ Menopause___

Number of days between periods ___Length of period__ Problems/pain_____________

Quantity of flow: Light __ Moderate __ Heavy __ Spotting between
periods__________

Pap history: Last Pap date: ________Results: ________ HPV Test Date: __________
Results:____________ History of abnormal Pap___
Treatment:____

Pregnancy history: Total number of pregnancies __Deliveries __Pre-term births______
Miscarriages: ___abortion: ___C-sections: ___Ectopic pregnancies _________________

Number of living children: __Adopted __Stepchildren ___Weight of largest baby________

Sexual history: Currently sexually active: ____ Age at first intercourse: _____________
Number of current partners ____ Sex with: men ___women ___both________________
Total number of partners: ___ History of STDs or possible exposure to STDs
____
____
Contraception: ________________________None needed___Trying for pregnancy_____
Previous methods of contraception:_______________ Problems with contraception_____
History of: Emotional abuse __Physical abuse __ Sexual abuse__

Medical history: Have you ever been diagnosed with or treated for problems related to: (explain)
____
____
____

Eyes ___Corrective lenses ___Cataracts ___ Glaucoma___
Ears ___Nose ___Throat ___Sinus ___ Hay fever___
Heart disease ___Hypertension ___Murmurs ___Rheumatic fever ___
Lung disease ___Asthma ___Pneumonia___
Stomach ___ Intestinal ___
Liver disorders ___GERD ___Hepatitis ___Ulcers___
Kidney disease___ Bladder disease ___Frequent bladder Infections___Incontinence___
Muscle ___Bone disease ___Fractures ___Arthritis ___
Skin problems ___Tattoos___ Piercing___
Brain ___Nerve disease ___Headaches ___
Psychiatric problems ___Mental illness ___Eating disorders ___
Diabetes ___Thyroid disease___Anemia ___Blood clots ___Blood transfusions___
Gynecology problems: Menstruation ___Breast ___Vagina ___Uterus ___
Ovaries ___Infertility ___Menopause___Cancer ___

Surgical history: Please list surgeries and/or hospitalizations

____
____

Family history: Include parents, grandparents, aunts, uncles, siblings & children

Birth defects: ____

Breast cancer: ____

Ovarian cancer:____

Uterine cancer:____
Colon cancer: ____
Heart disease: ____
Hypertension: ____
Diabetes: ____
High cholesterol____
Osteoporosis: ____
Bleeding: ____
Blood clots: ____
Mental retardation: ____
Alzheimer's: ____
Suicide: ____
Mental illness: ____
Alcohol or drug problems: ____
Are you of eastern European (Ashkenazi)Jewish decent? ________________________

Name____

Please complete and bring these forms with you to your appointment.

Review of symptoms: Are you currently experiencing problems with:

General well being: Fever/chills__ Fatigue__ Weight loss__

ENT: Vision loss__ Discharge or pain__ Earache__ Runny nose or sore throat__ Dental problems__

Cardiovascular: Chest pain__ Irregular heartbeat__ Swelling of lower legs__

Respiratory: Cough __ Wheeze__ Shortness of breath__

Gastrointestinal: Nausea__ Vomiting__ Constipation__ Diarrhea__ Reflux__ Bleeding__

Genitourinary: Vaginal discharge, odor or itching__ Urinary incontinence__ Urinary pain or frequency__ Abnormal vaginal bleeding or spotting__ Pain or bleeding with intercourse __ Breast lumps, pain or discharge__ Concerns about sexual life or functioning __

Musculoskeletal: Joint pain__ Stiffness__ Arthritis__

Skin: Rash__ Itching__ Dryness__ New moles__ Sores___

Neurological: Headaches__ Numbness__ Weakness__ Dizziness/vertigo __

Psychiatric: Depression__ Anxiety__ Memory loss__ Insomnia__

Endocrine: Heat/cold intolerance __Thirst __ Hair loss/growth__ Hot flashes__ Weight change__

Hematology/lymphatic: Severe bruising__ Easy bruising __ Enlarged lymph glands__

Allergic/immunological: Seasonal allergies__ Persistent infections__
Other:____

Health maintenance: Please date immunizations/tests/exams <u>since your last visit</u>:

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:
____
____