Well Woman Annual Preventative Care

Preferred Name:______________________________ **Age:**_____ **Last period:**________________

Period: Regular Irregular Menopause Hysterectomy Ablation IUD Type:__________ Birth Control pills

Please list any questions, symptoms, concerns or anything else that you would like to discuss in addition to your annual.

Please answer the following questions to the best of your ability.

New medical conditions or surgeries since your last visit: ☐ None______________________________

____

____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the Days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

3. Are you currently in a relationship where your partner makes you feel unsafe? ☐ Yes ☐ No

4. In the past, have you experienced physical or emotional abuse? ☐ Yes ☐ No

Drug Allergies ☐ None ☐ Yes, List with reaction:______________________________

Latex Allergy ☐ Yes ☐ No

Current Medications: (circle if refill needed) ______________________________

____

____

Sexually Active: ☐ Yes ☐ No ☐ Not currently Partner: ☐ Male ☐ Female ☐ Both

Current Contraception:____________________ Do you want to change your current method? ☐ Yes ☐ No

History of STD's? ☐ Yes ☐ No Type?______________________________

Occupation:__________________ Relationship Status:__________________ Partner's Name:______________

Number of pregnancies: None_____ Full term_____ Preterm:_____ Miscarriage:_____ Termination:_____

Review of symptoms: Check any of the following that you are **currently experiencing** ☐ **NONE**

General:	☐ Extreme Fatigue	☐ Depression	☐ Fever	
	☐ Weight gain____lbs	☐ Weight loss____lbs	☐ Cold intolerance	☐ Heat intolerance
Skin:	☐ Rash	☐ Change in mole		
Respiratory/ Cardiac:	☐ Shortness of breath	☐ Cough	☐ Chest pain	☐ Palpitations
Breast:	☐ Lump	☐ Pain	☐ Redness	☐ Nipple discharge
Gastrointestinal:	☐ Abdominal pain	☐ Black or bloody stools	☐ Bloating	☐ Diarrhea
	☐ Constipation	☐ Nausea	☐ Vomiting	☐ Change in bowel movements
Gynecologic:	☐ Abnormal bleeding	☐ Pain during sex	☐ Vulvar lump	☐ Painful cramps
	☐ PMS Symptoms ____________			☐ Genital herpes
	☐ Menopausal symptoms____________			☐ Genital warts / HPV
	☐ Vaginal discharge			
Urinary:	☐ Loss of urine	☐ Pain with urination	☐ Urinary frequency	☐ Urgency
Musculoskeletal:	☐ Muscle aches	☐ Muscle weakness		
Neurologic:	☐ Change in headaches	☐ Numbness	☐ Dizziness	

For Nursing and Doctors: Height__________ Weight__________ BP__________

Orders: ☐ Pap smear ☐ Mammogram ☐ Labs ☐ DXA ☐ STI ☐ GC/CT ☐ Immunizations __________

Any new family history of:

- ☐ **Breast cancer** **Relationship / Age of onset** ______________________________
- ☐ **Colon cancer** **Relationship / Age of onset** ______________________________
- ☐ **Ovarian cancer** **Relationship / Age of onset** ______________________________
- ☐ **Other** **Relationship / Age of onset** ______________________________

Social History:

Tobacco Use: ☐ Never smoked ☐ Current Smoker ☐ Smokeless Tobacco ☐ Former Smoker

Ready to quit? ☐ Yes ☐ No

Packs of cigarettes each day: ______________ Number of years smoked? ______________

E-cigarettes: ☐ Never smoked ☐ Current Smoker ☐ Former Smoker Ready to quit? ☐ Yes ☐ No

Alcohol use: Do you drink alcohol? ☐ Yes ☐ No If yes, Drinks each week: ______________________

Recreational drug use: ☐ Yes ☐ No

Type: ☐ Marijuana ☐ Methamphetamine ☐ Ecstasy ☐ Cocaine ☐ Heroin ☐ Prescription Drug

Vaccinations: Please document dates given, if requesting Vaccinations today please circle

Flu shot: (recommended yearly) ______________________________

TdaP - Tetanus, Diphtheria, and Pertussis or whooping cough (recommended every 10 yrs) ______________

Shingles or Shingrix: (recommended after age 50) ______________________________

Pneumococcal: (recommended after age 60 OR younger with risk factors) ______________________

Gardasil: (HPV Immunization - 3 dose series) ______________________________

Health Screening:

Hepatitis C blood test (one time testing for those born 1945-1965) ______________________

Have you had recent blood work? Who has the results? ______________________

What other doctors do you have: ______________________________

____

These questions cover important gynecological issues for all women. We strongly encourage everyone to have a Primary Care Physician to cover other health issues.

Please register for chart access at https://myhealth.stanfordhealthcare.org

POS Reorder # 1607475

Dear Patient:

Medicare has many rules and requirements regarding physician-patient interactions, physical exams and billing. Medicare will pay for a well woman breast and pelvic exam with a pap smear every 2 years.

If you have any of the following "high-risk factors" for vaginal or cervical cancer, Medicare may pay for a yearly breast and pelvic exam with a pap smear. Please inform your physician if you have any of these risk factors.

The high-risk factors as determined by Medicare are:

- **Onset of sexual activity under 16 years of age**
- **Five or more sexual partners in a lifetime**
- **History of sexually transmitted disease (including HIV infection)**
- **Fewer than three negative Pap smears or no Pap test within the previous 7 years**
- **Prenatal exposure to DES**

If you do not have a high-risk factor and are seen within two years of your last exam, your exam may be denied by Medicare and you will be billed for the service. The fee will not be over the estimated cost listed on the Advanced Beneficiary Notice (ABN) form provided to you.

Additional problems may be addressed during an exam and will be billed separately to Medicare and are usually a covered benefit.

Should you have any questions, please ask your nurse or physician.

Stanford HEALTH CARE

Patient Name: Medical Record Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for Pelvic and Breast Exam and/or Pap Smear below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Pelvic and Breast Exam and/or Pap Smear below.

Pelvic/Breast Exam and/or Pap Smear	Reason Medicare May Not Pay: Medicare covers these services once every 24 months.	Estimated Cost: $104 Exam: $47.54 Pap: $55.01

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Pelvic/Breast Exam and/or Pap Smear listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1**. I want the Pelvic/Breast Exam and/or Pap Smear listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2**. I want the Pelvic/Breast Exam and/or Pap Smear listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3**. I don't want the Pelvic/Breast Exam and/or Pap Smear listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

For Pap Test!

Patient Name: ______________________ Medicare ID Number: ________________

Advance Beneficiary Notice of Noncoverage (ABN)

Note: If Medicare does not pay for lab tests checked in box below, you may have to pay. Medicare does not pay for everything, including care that you or your health provider have found reason to think you need. We expect Medicare may not pay for the lab tests checked in box below.

Checked Lab Tests Only:	☐ Human papilloma virus, high-risk (HPV-HR) 87624 ☐ HPV genotyping (types 16, 18 & 45) 87625 ☐ Chlamydia trachomatis 87491 ☐ N. gonorrhea 87591 ☐ Trichomonas vaginalis 87661 ☐ other: ____________ ☐ other: ____________ ☐ other: ____________	☒ Cytopathology, cervical or vaginal, liquid-based thin layer preparation w/ automation assisted screening 88175 ☐ Cytopathology requiring interpretation by pathologist 88141 ☐ other: ____________ ☐ other: ____________ ☐ other: ____________
Reason Medicare May Not Pay:	Medicare may not pay for these tests as a screening test, or may not pay for these tests for your condition.	Medicare may not pay for these tests as a routine screening test in a frequency as ordered for you.
Estimated Cost:	$47-100 per test	$35-75 per test

What you need to do now:

- Read this notice so that you can make an informed decision about your care.
- Ask us any question that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have. Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose an option for you.

☐ **OPTION 1.** I want the *lab tests* checked above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for payment, but **I can appeal to Medicare** by following directions on the MSN. If Medicare does pay, you will refund any payments that I have made to you, less co-payments or deductibles.

☐ **OPTION 2.** I want the *lab tests* checked above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I do not want the *lab tests* checked above. I understand with this choice that I am **not responsible for payment,** and I cannot appeal to see of Medicare would pay.

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Stanford HEALTH CARE

Patient Name: Medical Record Number:

Advance Beneficiary Notice of Noncoverage (ABN)

***NOTE:** If Medicare doesn't pay for Fecal Occult Blood Test below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Fecal Occult Blood Test below.*

Fecal Occult Blood Test G0328	**Reason Medicare May Not Pay: Medicare covers Fecal Occult Blood Test only once every 12 months.**	**Estimated Cost: $ 14.19**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Fecal Occult Blood Test listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1**. I want the Fecal Occult Blood Test listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2**. I want the Fecal Occult Blood Test listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3**. I don't want the Fecal Occult Blood Test listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

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