Women's Health and Aesthetics
Seasons
Dr. Yamaki
2319 SW 320th Street
Federal Way, WA 98023
Tacoma Phone: (253) 927-5053
Seattle Phone: (253) 838-8733
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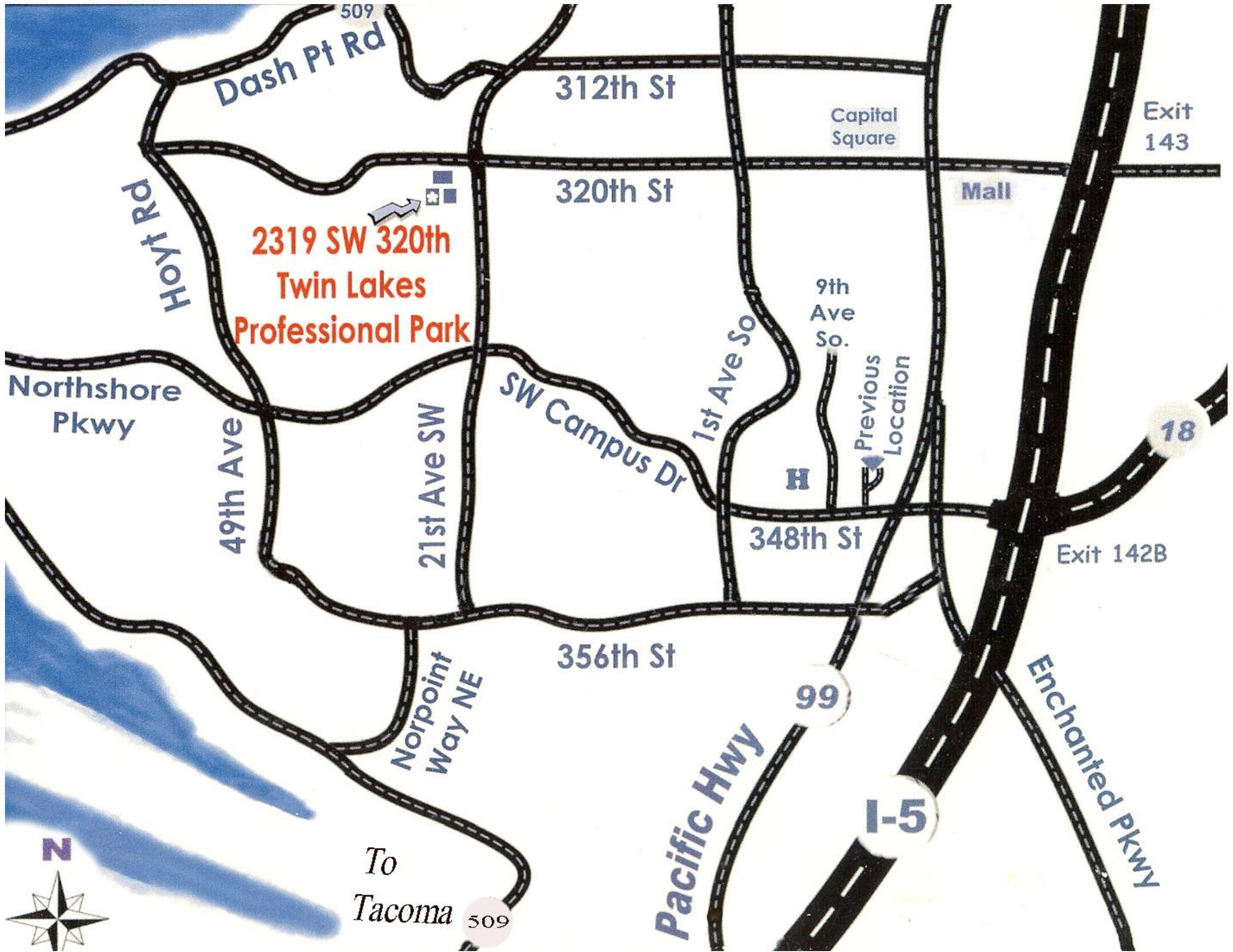
In preparation for your upcoming visit please fill out the attached forms as accurately as possible and bring these forms to your appointment. If you are self referred and have recently had diagnostic tests, labs or other relevant medical encounters, please bring or have these records faxed to our office, as well.

When you arrive for your appointment there will be some additional administrative details to complete, and our nurses will need to take some time to enter your medical history into our electronic record system before you are seen. Your appointment time is when we want you to arrive so there is ample time to put together your electronic record before being seen. Please allow yourself up to two hours for the total time of your appointment. Please be sure to bring your insurance card(s), and if your insurance has a co-pay, please be prepared to pay this at the time of your appointment.

A map to our office is on the back of this page, and you may wish to learn more about us or get directions from our web site: www.dryamaki.com. We are on the main road (320th street) in Federal Way, but 10 minutes from the downtown shopping area, in a residential area called Twin Lakes (**SW** 320th). We would be happy to assist you with directions so please don't hesitate to call.

Thank you for choosing Seasons – Women's Health and Aesthetics for your healthcare needs. We look forward to meeting you soon.



2319 SW 320th Street

Twin Lakes Professional Park
Federal Way, WA 98023

(253) 927-5053 or (253) 838-8733

Please Complete, Sign and Make Corrections, as Needed

PATIENT INFORMATION

❑ Mrs. ❑ Ms. ❑ Miss	**Last Name:** .	**First**: .	**Middle:**
Referring Provider:		PCP:	
Birth Date:	Age:	**Social Security #**:	
Marital Status (circle): Single, Married, Divorced, Separated, Widowed, Other			
Please Indicate the Best Way for Us to Call You.	**Cell Phone:**	**Home phone #**:	
Address:	**Work Phone:**		
Email:	Occupation:	Employer:	

INSURANCE INFORMATION

Insurance coverage? ❑Yes ❑ No	Other Coverage:		
Person Responsible for Bill:	Address:	Phone: Type (circle): (h) (c) (w)	
Name of **Primary Insurance**:	**Subscriber's name:**	**Group #:**	**Policy #:**
Subscribers Employer:	**Subscriber's Birth Date**:	Copay:	
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of **Secondary Insurance**:	**Subscriber's name:**	**Group #:**	**Policy #:**
Subscriber's Employer:	**Subscriber's Birth Date**:	Copay:	
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship:	Phone no.: ( )	Type of phone

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Yamaki's office or my insurance company to release any information required to process my claims.

Patient/Guardian signature: **Date**

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Disclosure Authorization to a Third Party (Friends and Family)

Your medical record contains privileged and confidential information which is protected by law. For convenience, some patients wish to allow relatives, or others access to test results or other verbally transmitted health care information. If you wish to allow anyone to receive such verbal information, please list the name and relationship in the spaces provided. Copies of your chart or other written information are not covered by this authorization. Unless otherwise specified, this authorization will remain in effect until revoked in writing by you.

____

CHOOSE ONE OF THE TWO CHOICES BELOW:

_____ I give permission to the office of Estelle Yamaki, MD to discuss information relating to my medical condition to the person(s) identified below:

_______________________________________ Relationship _____________________

_______________________________________ Relationship _____________________

OR

_____ I do not wish to authorize disclosure of my protected health information to anyone other than those authorized by law.

____

ALSO CHECK BELOW IF APPLICABLE:

_____ If I cannot be reached directly by telephone. I authorize the staff members of Estelle Yamaki, MD to leave a detailed message on my phone messaging system.

____ ___________________

Patient Printed Name Date of Birth

____ ___________________

Patient Signature Date

HISTORY FORM

Name. . Today's Date__________

GYNECOLOGIC HISTORY

Dates of 1st day of last two menses: ________________ and ________________ **OR** no menses greater than one year due to (please circle) menopause, ablation, non-cycling birth control, other______________.

Total number of: Pregnancies ____, Miscarriages _____, Deliveries _____, Termination of pregnancies _____

Circle what you currently use for birth control: abstinence, attempting pregnancy, birth control pills _______________, condoms, Depo-Provera injection, diaphragm, Implanton rod, IUD (Paragard, Mirena), menopause, Nuva Ring, Ortho Evra patch, rhythm method/natural family planning, spermicide, Today's sponge, Tubal, vasectomy, withdrawal.

Check if you have or have had any of the following:

current	*past*		*current*	*past*		*current*	*past*	
___	___	Heavy menses	___	___	Uterine fibroid or polyps	___	___	Tubal ligation
___	___	Severe pain with menses	___	___	Endometriosis	___	___	Hysterectomy
___	___	Bleeding between menses	___	___	Ovarian cysts	___	___	Ovaries removed
___	___	Bleeding after intercourse	___	___	Venereal disease	___	___	Breast surgery
___	___	Pain with intercourse	___	___	Dysplasia/abnormal pap/HPV	___	___	D&C
___	___	Breast lump	___	___	Colposcopy/biopsy	___	___	Ablation
___	___	Nipple discharge	___	___	Cryotherapy (freezing),	___	___	Caesarean section
___	___	Menopausal symptoms	___	___	LEEP, Laser, or Cone biopsy of the cervix			

PREVENTION HISTORY

Date last: Annual well woman exam _______ Pap smear _______ Mammogram _______ Bone density scan ______
Colonoscopy _______ Tetanus immunization _______ HPV immunization #1 _______ #2 _______ #3 _______

PAST MEDICAL HISTORY

Please list any medications you are presently taking including over-the-counter medications, vitamins, herbs, etc.:

SEE ATTACHED FORM

Do you smoke or use other tobacco products? Yes ___ No ___ If yes, how much _____________ How long ________
Do you drink alcoholic beverages? Yes ___ No___ If yes, how much ________________ How often _____________
Do you use any street drugs? Never In the past (last used____________) Yes, using _________________________
Please list any operations, serious injuries, illnesses or hospitalizations and the approximate date.

_____________________________________ _______ _____________________________________ ______
_____________________________________ _______ _____________________________________ ______
_____________________________________ _______ _____________________________________ ______

FAMILY HISTORY

Please list any significant illness or disease in your immediate family:

	Age if living	Indicate any serious illness/disease	Cause of death/Age
Mother			
Father			

Indicate if you or anyone in your family have had any of the following (myself [X], mother [M], father [F], brother [B], sister [S], daughter [D], son [SO], paternal aunt [PA], maternal grandfather [MGF], etc.):

Heart trouble ____________________ High blood pressure _____________________ Stroke ____________________
Epilepsy ________________________ Kidney disease or stones ________________ Diabetes __________________
Arthritis ________________________ Phlebitis _______________________________ Tuberculosis _______________
Rheumatic fever _________________ Mental/emotional problems _______________ Thyroid disease _____________
Hepatitis/jaundice ________________ Blood clots in legs or lungs________________ Alcoholism ________________
Drug abuse _______________________ Cancer (type) ____

Continued on back side

SOCIAL HISTORY
Lives with ____
Work/occupation____
Current stressors____
New sexual partner(s) since last visit_____

Unfortunately, many women in our society find themselves in situations or relationships that are unhealthy or sometimes violent; do you have concerns about your safety at home? ______________________________

REVIEW OF SYSTEMS
Please circle if you have a significant problem in any of the specific areas noted below and comment on special problems or current treatment.
Constitutional: unexplained weight change, fatigue, fever, insomnia, dizziness
____
Eyes: vision change, blurred vision, pain, redness, contacts/glasses
____
Ear/Nose/Throat: allergies, trouble hearing, hoarseness, enlarged thyroid
____
Cardiovascular: chest pain, palpitations, heart murmur, swelling, anemia
____
Respiratory: wheezing, asthma, shortness of breath, cough, TB exposure
____
Gastrointestinal: heartburn, nausea, vomiting, constipation, diarrhea, abdominal pain, blood in the stool, hemorrhoids, ulcer ____
____
Genitourinary: urgency, frequency, pain with urination, pain with full bladder, waking up to urinate two or more times at night, blood in urine, leaking of urine ______________________________________
____
Musculoskeletal: muscle weakness, joint pain or swelling, broken bone(s)
____
Skin: rash, hair loss, acne, jaundice, eczema, psoriasis
____
Neurological: fainting, seizures, numbness/tingling, tremors, headaches
____
Mental health: depression, nervousness, crying, panic attacks, memory problems
____
Endocrine: heat or cold intolerance, excessive thirst or hunger
____
Hematological/Lymph: frequent bruising, nosebleeds, swollen lymph nodes
____
Are you at risk of possible exposure to the AIDS virus? For example:

Past blood transfusions? Yes___ No___
Exposure to blood or blood products? Yes___ No___
IV drug abuse? Yes___ No___
Multiple sexual partners? Yes___ No___
Other risk group? ____________________________

Please feel free to attach any other recorded information that you feel will be of importance to the provider in evaluating your health problems.

Medication List

Name: . . **Birthday:**

Allergic To: ____
____

Allergic Reaction: ____

Pharmacy: **Rx phone:**

Pharmacy Address/ City:

List all medicine you are currently taking: Prescription and over-the-counter medications (example aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers, nitroglycerin).

Medication Name	Dose (How much)	Frequency (How often)

Over-the counter Medications/Vitamins/Herbals

Medication Name	Dose (How much)	Frequency (How often)

Today's Date: _____________