ADVANCED GYNECOLOGY

FEMALE
New Patient Demographics

Form completed by ☐ Patient ☐ Other *Name*: _____ *Relationship to patient* _____

DEMOGRAPHICS

Last Name: First: MI	DOB: (MM/DD/YYYY) Gender: ☐ Male ☐ Female ☐ Other:
Address: City:	Social Security No.
City: State: Zip:	Phone:
Primary Care Physician: (Name)	(Phone)
Referring Physician: (Name)	(Phone)
Emergency Contact: (Name) (Phone) (Relationship)	

Additional Information

Email:	
Race: Ethnicity:	Preferred Language: ☐ English ☐ Spanish ☐ Other
Preferred Pharmacy: (Name)	(Phone)
Do you have an Advance Directive (Living Will)? ☐ Y ☐ N	Preferred Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have been provided a copy of Advanced Gynecology's Privacy Practices as required by the Health Insurance Portability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I authorize Advanced Urology to release my health information to persons listed below:

☐ Same as Emergency Contact	Other person: Name:_____ Relationship: _____ Phone: _____

By signing this document, I acknowledge the following:

- I have been provided a copy of Advanced Gynecology's Privacy Practices
- I have reviewed this authorization to release my medical records and confirm it is correct.
- I understand that this authorization will remain in effect for a period of one (1) year, unless revoked.
- I may revoke this authorization at any time by writing to: Advanced Gynecology, ATTN: Medical Records
- 1561 Janmar Rd., Snellville, GA 30078: The revocation will become effective upon receipt of the notice.

_____ _____

Signature of patient (or guardian) Date

OFFICE

For Office Use Only

Staff Initials:	☐ Patient Photograph	**Scan ALL patient documents**		
		☐ Pt. ID	☐ Insurance Card	
		☐ Pt. Demographics	☐ Pt. History	☐ Pt. Surveys

ADVANCED GYNECOLOGY

Annual – Financial Policy & Consents

PAYMENT POLICY

Please *initial and sign* to your acknowledgement and consent for Medical Treatment and Payment Policy.

Thank you for choosing Advanced Gynecology as your provider. We are committed to providing you with quality and affordable health care. Please be sure to carefully read our payment policy. A copy will be provided upon request.

- ***Insurance.*** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- ***Co-payments and deductibles***. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a collection agency, a $100 collections processing fee will be added to any outstanding balance.
- ***Non-covered services***. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- ***Proof of insurance***. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- ***Claims submission***. We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.
- ***Coverage changes***. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

_____ **INITIAL HERE**

CONSENT TO MEDICAL TREATMENT

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.

- I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Advanced Gynecology.

- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, I consent to testing for HIV or Hepatitis C & B.

_____ **INITIAL HERE**

SIGNATURES

By signing below, I acknowledge that I have reviewed Advanced Gynecology's payment policy and consent to medical treatment.

Print name of person signing: _____ Relationship to patient: _____

_____ _____

Signature of patient (or guardian) Date

ADVANCED GYNECOLOGY

Medical Release

Request for Healthcare information
Please forward the healthcare records of the following patient
Fax to 1.888.972.8051 or mail to 1357 Oconee Connector, Bldg 100 Watkinsville, GA 30677

Authorization to obtain protected healthcare information

Patient Name (LAST) _____ (FIRST) _____ (MI) _____ (Suffix) _____

Date of Birth: _____/_____/_____ Phone: _____

☐ I authorize Advanced Gynecology to obtain and the named facilities to release to Advanced Gynecology my healthcare information.

This release applies to:

☐ All my healthcare information

☐ Healthcare information related to the following treatment, condition or dates

_____

☐ Other

_____

For Office Use Only

Facility: (Name) _____

Address:

_____

Phone: _____

(Fax)_____

_____ _____/_____/_____

Signature of patient (or guardian) Date

_____ _____

Print name of person signing Relationship to patient

ADVANCED **GYNECOLOGY**

Patient History

Patient Name: _____ **DOB**:_____

	Reason for today's visit
	Height: Weight:

CURRENT MEDICATION

List ALL current medications (including over the counter, birth control, vitamins, herbals & prescriptions)

If you do not take any medications please mark ☐ N/A

Medication Name & Dose	*Medication Name & Dose*

MED HISTORY

List ***ALL*** current or past medical conditions

If you do not have any medical conditions please mark ☐ N/A

ALLERGIES

Are you allergic to: ☐ Latex ☐ Band-aids/Adhesives ☐ Iodine ☐ Shellfish ☐ IVP Dye

If you do have any medication allergies please mark ☐ No Known Drug Allergies

List name of medication allergy	*Reaction to medication*

SURG HISTORY

List ***ALL*** surgeries including the year

If you have never had surgery please mark ☐ N/A

HOSPITALIZATION

List ***ALL*** hospitalizations including the year

If you have never been hospitalized please mark ☐ N/A

ADVANCED **GYNECOLOGY**

Patient History

FAMILY HISTORY

Do you have a personal or family history of cancer?

(i.e. breast, ovarian, uterine, vagina/vulvar, cervical, colon, bladder)

☐ **Yes** ☐ **No**

Relationship	**Type of Cancer**
Mother ☐ Alive ☐ Deceased ☐ Unknown Cause of death:	**Father** ☐ Alive ☐ Deceased ☐ Unknown Cause of death:

SOCIAL HISTORY

Tobacco Use Do you use tobacco products? ☐ No ☐ Yes ☐ Former Smoker (Quit Date _____)

If yes, (How many years_____) (Packs/Day_____)

Alcohol Use Do you drink alcohol? ☐ No ☐ Yes

If yes, how many drinks per (Day _____) (Week _____) (Year _____) Date of last drink (____/____/____)

Drug Use Do you routinely use any illegal substances? ☐ No ☐ Yes (please list_____)

OBGYN HISTORY

Pregnancy History

Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown

Total # pregnancies _____ # Vaginal births _____ # C-sections _____ # Abortions _____ # Miscarriages _____

Largest infant weight _____ History of: ☐ Forceps ☐ Vacuum ☐ Episiotomy ☐ 3/4th degree tear /birth injury

Menstrual History

Date of Last Period (____/____/____) Age of first period _____ Total cycle length (no. of days) _____

☐ <21 days apart ☐ 21-35 days ☐ >35 days ☐ 1-3 pads/day ☐ 4-6 pads/day ☐ 7+ pads/day

Do you experience: ☐ Large clots ☐ Accidents ☐ Severe Pain ☐ Headaches ☐ Nausea/Diarrhea

Have you ever had endometrial biopsy? ☐ Yes ☐ No

Health Screening History

Date of Last Pap Smear (____/____) ☐ Normal ☐ Abnormal (Result: _____) ☐ Colposcopy ☐ LEEP

Date of Colonoscopy (____/____) Date of Bone Density Scan (____/____)

Date of Mammogram (____/____) Location _____

Menopause History

Are you currently post-menopausal? ☐ Yes ☐ No ☐ Unknown Date of Last Period (____/____/____)

Do you use hormonal replacement therapy? ☐ Yes ☐ No (Type: oral/transdermal/patch/pellets/other)

Do you have history of : ☐ postmenopausal bleeding ☐ hot flashes/night sweats ☐ low libido

Gyn Surgery History

Have you ever had a **hysterectomy**? ☐ Yes ☐ No (Route: Vaginal / Robotic / Laparoscopic / Abdominal)

- If yes, was the cervix removed? ☐ Yes ☐ No Were the ovaries and tubes removed? ☐ Yes ☐ No

Have you ever had any surgery involving reproductive organs, urethra/bladder, anus/rectum? ☐ Yes ☐ No

- If yes: please list _____

ADVANCED GYNECOLOGY

Patient History

PERTINENT MEDICAL HISTORY *If you do not have these conditions, please skip to next section and mark ☐ **N/A***	
☐ Sexually Transmitted Disease (STD) ☐ Fibroids ☐ Endometriosis ☐ Ovarian cysts ☐ Polycystic ovarian syndrome ☐ Clotting disorders / family history of clotting disorders ☐ Easy bruising/ Easy bleeding ☐ Stroke / Pulmonary Embolism ☐ History of Deep Vein Thrombosis (DVT)	☐ Congestive heart failure / Coronary Artery Disease ☐ Uncontrolled Hypertension ☐ Migraines with aura ☐ Seizures / taking anti-convulsant medication ☐ Gallbladder disease ☐ Acute Liver disease or Liver tumors ☐ History of bariatric surgery ☐ Anemia ☐ Diabetes
☐ Hemorrhoids ☐ Anal fissures ☐ Anal fistulas ☐ Inflammatory Bowel Disorder	☐ Colorectal cancer ☐ Slow GI motility ☐ Celiac disease ☐ Hirschsprung's disease
☐ Glaucoma ☐ Gastroparesis ☐ Myasthenia Gravis ☐ Dementia ☐ QT Prolongation	

Patient History completed by:

☐ Patient

☐ Other Name: _____ Relationship to patient:_____

ADVANCED **GYNECOLOGY**

Bladder Survey

Patient Name: _____ **DOB**:_____

BLADDER SYMPTOMS

If you do not have these symptoms, please skip to next section and mark ☐N/A

How much does this bother you?				
☐ Frequent Urination	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ A sudden controllable urge to urinate	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Small amounts of urine leakage (drops)	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Leakage associated with a feeling or urgency (that is, a strong sensation of needing to go the bathroom)	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Leakage related to coughing, laughing, sneezing or laughing	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Difficulty emptying your bladder	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Pain or discomfort in the lower abdomen or genital region	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Waking up at night with the urge to urinate (nocturia)	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit

If you checked **YES** to any of the above problems, how long have you been experiencing this?

☐ Less than 1 year ☐ About 1 year ☐ About 2 years ☐ 3-5 years ☐ Greater than 5 years

Have you ever had any of the following treatments for your bladder?

☐ Sling ☐ Urethral bulking ☐ Botox in bladder ☐ PTNS ☐ PNE/Interstim ☐ Hydrodistension

☐ Burch/MMK procedure ☐ Pelvic floor physical therapy ☐ Other _____

Have you ever had any of the following medications for your bladder?

☐ Detrol/Tolterodine ☐ Ditropan/Oxybutynin ☐ Vesicare/Solifenacin ☐ Sanctura/Tropsium

☐ Toviaz/Fesoterodine ☐ Enablex/Darifenacin ☐ Myrbetriq/Mirabegron ☐ Cardura/Flomax

☐ Elmiron / PPS ☐ Methenamine/Hipprex ☐ D-Mannose ☐ Antibiotics

Have you ever had any of the following medication side effects for your bladder?

☐ Dry mouth ☐ Dry Eyes ☐ Constipation ☐ Urine retention / Impaired bladder emptying ☐ Other

How much does your bladder usually affect your:				
☐ Ability to do household chores (cooking/laundry/house cleaning)?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Ability to do physical activities such as walking, swimming or other exercises?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Entertainment activities such as going to a movie or concert?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Ability to travel by car or bus for distance greater than 30 min away from the house?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Participating in social activities outside your home?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Emotional health (nervousness/depression, etc?)	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Feeling frustrated?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit

ADVANCED GYNECOLOGY

Bladder Survey

URINE LEAKAGE

If you do not have these symptoms, please skip to next section and mark ☐N/A

If **YES**, how often do you leak? ☐ Every day ☐ A few times / week ☐ A few times / month ☐ Rarely

Do you leak with ☐ Cough ☐ Laugh ☐ Sneeze ☐ Exercise ☐ Sex ☐ Positional Changes ☐ Urgency

How many pads per day _____ ☐ Small pads ☐ Moderate pads ☐ Large pads ☐ Depends

How much urine do you lose at a given time ☐ Drops ☐ Small Splashes ☐ More

Do you ever leak without sensory awareness? ☐ Yes ☐ No

Do you ever leak while asleep? ☐ Yes ☐ No

FREQUENCY

If you do not have these symptoms, please skip to next section and mark ☐N/A

If **YES**, how often do you go to the bathroom:

DAY: ☐ 5-6x /day ☐ 7-8x /day ☐ 9-10x /day ☐ 11 or more /day

OVERNIGHT: ☐ Zero times /night ☐ 1-2x / night ☐ 3-4 or more x / night

INCOMPLETE BLADDER EMPTYING/WEAK STREAM

If you do not have these symptoms, please skip to next section and mark ☐N/A

Have you noticed any of the following with regard to your urine stream:

☐ Slow to start (hesitancy) ☐ Weak stream ☐ Slow stream ☐ Intermittent stream

☐ Dribbling after stream ends ☐ Double voiding

Do you need to do any of the following to help your bladder empty?

☐ Bearing down ☐ Pushing on lower abdomen ☐ Pushing up on vaginal bulge ☐ Position changes

☐ Catheter usage

RECURRENT BLADDER INFECTIONS / BLADDER PAIN

If you do not have these symptoms, please skip to next section and mark ☐N/A

Have you had a urinary tract infection (UTI) with a positive culture in the last year ☐ Yes ☐ No

If yes, about how many have you had in the past year? _____

Please list date of your most recent one: _____

Have you ever been hospitalized for a UTI? ☐ Yes ☐ No

Do you think you may have one today? ☐ Yes ☐ No

Have you noticed any blood in your urine? ☐ Yes ☐ No

DO you have any burning or pain with urination? ☐ Yes ☐ No

Do you ever have pain associated with a full bladder? ☐ Yes ☐ No

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131

ADVANCED **GYNECOLOGY**

Colorectal History

Patient Name: _____ **DOB:**_____

BOWEL FUNCTION

If you do not have these symptoms, please skip to next section and mark ☐N/A

☐ Do you have constipation?	☐ Yes	☐ No		
☐ Do you have diarrhea?	☐ Yes	☐ No		
On average, how many bowel movements do you have a week?				
How much does this bother you?				
☐ Do you need to strain hard to have a bowel movement?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Do you feel that you have not completely emptied your bowels at the end of a bowel movement?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Loss of stool beyond your control with well-formed stool	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Loss of stool beyond your control with loose stool	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Pain with you pass stool	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Strong sense of urgency to rush to the bathroom to have a bowel movement	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Feeling a bulge during or after a bowel movement?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
How much does your bowel or rectum usually affect your:				
☐ Ability to do household chores (cooking/laundry/house cleaning)?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Ability to do physical activities such as walking, swimming or other exercises?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Entertainment activities such as going to a movie or concert?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Ability to travel by car or bus for distance greater than 30 min away from the house?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Participating in social activities outside your home?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Emotional health (nervousness/depression, etc?)	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Feeling frustrated?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit

STOOL LEAKAGE

If you do not have these symptoms, please skip to next section and mark ☐N/A

☐ How often does this occur?	☐ Daily	☐ Weekly	☐ Monthly	☐ Every few months
☐ Do you use pads/liners for leakage?	☐ Yes	☐ No	How many per day?	
How long have you been experiencing this?				

Have you had any of the following treatments for bowel leakage? ☐ Sphincteroplasty ☐ PTNS/Interstim

☐ Solesta ☐ Artificial sphincter ☐TOPAS ☐ Anal sphincter bulking ☐ Pelvic floor physical therapy

ADVANCED GYNECOLOGY

Gynecologic Survey

Patient Name: _____ **DOB**:_____

VAGINAL BULGE/PROLAPSE SYMPTOMS

If you do not have these symptoms, please skip to next section and mark ☐N/A

	How much does this bother you?			
☐ Pressure in lower abdomen	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Heaviness or dullness in the pelvic area	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ A bulge or something falling out that you can see or feel in your vaginal area	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Having to push on the vagina or around the rectum to have or complete a bowel movement	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Feeling of incomplete bladder emptying	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Having to push up on a bulge in the vaginal area with your fingers to start or complete urination	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit

- Have you ever had any of the following treatments for prolapse?

☐ Surgery (Type_____) ☐ Pessary ☐ Pelvic floor physical therapy

How much does your vagina or pelvis usually affect your ability to do:				
☐ Household chores (cooking/laundry/house cleaning)?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Physical activities such as walking, swimming or other exercises?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Go to entertainment activities such as going to a movie or concert?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Travel by car or bus for distance greater than 30 min away from the house?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Participate in social activities outside your home?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Emotional health (nervousness/depression, etc?)	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit
☐ Feeling frustrated?	☐ Not at all	☐ Somewhat	☐ Moderately	☐ Quite a bit

OTHER VAGINAL SYMPTOMS

If you do not have these symptoms, please skip to next section and mark ☐N/A

☐ Do you have vaginal dryness?	☐ Yes	☐ No
☐ Do you have any abnormal vaginal discharge?	☐ Yes	☐ No
☐ Do you have any vaginal or vulvar itching or irritation?	☐ Yes	☐ No

ADVANCED GYNECOLOGY

Gynecologic Survey

SEXUAL DYSFUNCTION *If you do not have these symptoms, please skip to next section and mark ☐N/A*	
☐ Are you sexually active?	☐ Yes ☐ No (Please circle) with Men Women Both
☐ Do you have pain with sex?	☐ Yes ☐ No
☐ Do any of the following restrict you from having a healthy sex life?	☐ Urine leakage ☐ Bowel leakage ☐ Vaginal Dryness ☐ Vaginal Bulge ☐ Lack of Interest ☐ Difficulty achieving orgasm

PELVIC PAIN *If you do not have these symptoms, please skip to next section and mark ☐N/A*	
☐ Do you currently have pelvic pain?	☐ Yes ☐ No
☐ Location (please describe)	
☐ How long have you had this pain?	_____ Days _____ Months _____ Years
☐ Severity?	(Please circle) Minimal Moderate Severe
☐ Pain Scale (0= no pain, 10= worse pain imaginable)	1 2 3 4 5 6 7 8 9 10
☐ Where does the pain radiate/spread?	
☐ What makes the pain worse?	
☐ What makes the pain better?	
☐ Have you tried any of these treatments for pelvic pain?	☐ NSAIDS / Ibuprofen ☐ Narcotics ☐ Elavil/Amitriptyline / Elmiron ☐ Neurontin/Gabapentin ☐ Muscle relaxants ☐ Valium Suppositories ☐ Uribel / Azo / Pyridium ☐ Pudendal nerve block ☐ Estrogen creams/tabs ☐ Laser therapy ☐ Bladder Instillations / Hydrodistension / Cystoscopy / Botox ☐ Other:

Narcotic and Opioid Patient Prescriber Agreement (PPA)

- Pain and pain treatment are different for each person. Narcotic and opioid medicines are a type of medicine used to reduce moderate to severe pain. Narcotic and opioid medicines can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines.

- My prescriber and I may also try alternative or additional treatment options for my condition, including: Non-opioid medicines, Physical therapy, appropriate exercises, Self-management techniques and coping strategies, or surgical or other medical procedures.

- Using narcotic and opioid medicines may cause:
  - *Physical dependence*: If the medicine is suddenly stopped I may experience withdrawal symptoms.
  - *Tolerance*: Over time, I may need more medicine to get the same pain relief.
  - *Addiction*: I may develop an intense craving for the opioid medicine, even if I take it as prescribed. If someone in my family has been addicted to drugs or alcohol, I may be at greater risk for addiction.

- Narcotic and opioid medicines can impair my judgment and responses. I understand that I must be cautious if I drive or operate machinery or do any activity that requires me to be alert until I am sure I can perform such activities safely.

- Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid or narcotic medicine will increase the chance of side effect such as drowsiness, dangerously slowed breathing, and decreased alertness. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away.

- I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to try to treat my condition with an opioid medicine

- I told my prescriber about all the medicines I am taking, including any prescription, over-the-counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future.

- I will tell my prescriber if I am pregnant or planning to become pregnant

- I will not share this opioid medicine with other people.

- I will keep my opioid medicine in a secure place where other people cannot reach it.

- I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself.

- I understand that my prescriber may be required to check the Georgia Prescription Drug Monitoring Program before issuing a prescription for certain narcotics or opiates.

_____

Patient Signature Date