Welcome to Norton Children’s Gynecology! We are proud to be the only practice in Kentucky dedicated to the unique gynecology needs of children, adolescents and young women under the age of 21. All of our providers are trained in pediatric and adolescent gynecology specialty care.

This letter is to explain our office policies and practices designed to provide you with the best quality care.

1. Confidentiality: Kentucky state law requires that adolescents have access to confidential services in regards to sexuality, sexually transmitted disease screening, treatment and pregnancy and mental health screening. We encourage all of our patients to have open communication with their parents/guardians. However, in order to ensure all of our patient’s health care needs are being met, we provide patients an opportunity to discuss concerns in private, and use this time provide education on these issues.

2. No Show Policy: No shows are a huge burden to our practice. We ask that you notify us 48 hours before your scheduled appointment if you need to cancel or reschedule. If you have more than 3 no shows or a history of late cancellations you will be dismissed from the practice. You may also be charged a $25.00 fee for no showing to or cancelling your appointment in less than 24 hours.

3. Late Policy: We ask you to be on time for your appointments. You need to leave a little extra time for parking, as well as paperwork. If you are late we will reschedule your appointment in order to keep the office on schedule for the other patients who arrived on time.

4. Appointment Arrival Time: If you are a new patient to our practice or are scheduled for an annual check, you need to be at the office 30 minutes prior to your appointment time. This will allow enough time to complete the necessary paperwork before your appointment. If you are an established patient to our practice, please arrive 15 minutes prior to your appointment time for follow-up paperwork.

5. We will not be able to do hospital consults at hospitals outside the Norton system. If you experience an emergency situation and need to go to the emergency room go to the nearest Norton Children’s Hospital facility if 18 and under. If over the age of 18, please go to the closest Norton Hospital including Norton Audubon, Norton Women’s and Children’s, Norton Downtown, or Norton Brownsboro. Make sure to let the emergency room doctor know you are a patient in our practice, so they can contact us for necessary follow-up care.

6. On-Call Physicians: One of the physicians from our practice is on call after regular office hours. The on-call physician is for emergencies. If you have questions regarding non-emergent issues, medications, need prescription refills, or appointments you will need to call during business hours of 8:00am-4:30pm or use My Chart to send us correspondence.

Please sign that you have read and understand the office policies.

Signature: ______________________________________________________________________________

Date: ______________________________________________________________________________
Patient Visit Information Sheet

Name: ___________________________________ Age: ________ DOB: ____________

Email Address: ____________________________________________________________

1. What is the reason for your visit today?
   □ Birth Control   □ Annual Exam   □ Irregular Periods
   □ Painful Periods □ Heavy Periods □ Vaginal Irritation
   □ Vaginal Discharge □ Pelvic Pain □ Breast Problem
   □ Lichen Sclerosis □ Ovarian Cyst □ Endometriosis
   □ STD Screening □ Post-Op Visit □ Follow-Up
   □ Other (Please Specify) ____________________________________________________

2. If you are here for an annual visit, have you visited or are you planning to visit your primary care doctor this year for a wellness visit? ________

3. Who is accompanying the patient? ____________________________________________

4. Please list any allergies (latex, drugs) ________________________________________

5. What pharmacy do you use (Please list Name, City, and Street Address or Phone) ________________________________________________________________

6. Please list what medications you are currently taking:

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<tr>
<th>Drug Name</th>
<th>Dosage</th>
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7. Patient Symptomatic History (Please check if you are currently experiencing...)

   □ Fever/Chills □ Frequent Urination □ Breast Pain
   □ Weight Loss or Gain □ Painful Urination □ Nipple Discharge
   □ Changes in Sleep □ Leaking Urine □ Breast Mass/Lump
   □ Heart Problems □ Bedwetting >5yrs. old □ Eczema
   □ Fainting □ Muscle Spasms □ Rash
   □ Asthma □ Loss of Appetite □ Unwanted Hair Growth
   □ Coughing □ Nausea/Vomiting □ Acne
   □ Shortness of Breath □ Constipation □ Vaginal Discharge
   □ Anemia □ Abdominal Pain □ Vaginal Bleeding
   □ Bleeding Problems □ Diarrhea □ Thyroid Problems
   □ Pubic Hair Development □ Breast Development □ Diabetes
   □ High Blood Pressure □ High Cholesterol □ Migraines/Headaches
   □ Sports Injury □ Anxiety/Depression □ Seizures
   □ Other (Please Specify) ____________________________________________________

For Office Use Only:

WT: __________________________
HT: __________________________
BP: _______ / _______
P: __________________________
T: __________________________
LMP: _______________________
Cell: _______________________
Gardasil: □ 1 □ 2 □ 3
Flu Vaccine: □ Y □ N
8. **Does patient have her period?**
   - [ ] No
   - [ ] Yes – At what age did patient start? ________

9. **Patient Surgical History**
   - [ ] Ear Tubes
   - [ ] Wisdom Teeth
   - [ ] Tonsils
   - [ ] Adenoids
   - [ ] Cosmetic Surgery
   - [ ] Appendix
   - [ ] Hernia Repair
   - [ ] Fracture
   - [ ] Other ________________________________

10. **Patient/Family Medical History**
    (Please check if patient or anyone in patient’s family have/had any of the following medical conditions. Some will not apply to the patient, but could to a family member. If you have filled this history out in the past year and there have been no changes, please check no changes at the bottom.)

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<th>Birth Defects</th>
<th>Bladder Problems</th>
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[ ] Adopted  [ ] Family History Unknown  [ ] Maternal Family History Unknown  [ ] Paternal Family History Unknown  [ ] No Changes

Is there any additional information about today’s visit, family history, or current living situation we should be aware of? ________________________________

________________________________________________________________________________________
1. Do you have any concerns about your child’s health, weight or nutrition?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

2. Have there been any changes or stresses for your family in the last year?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

3. Have you noticed any changes in your child’s behavior, such as unusual anger or irritability, withdrawal,  
secrecy, sadness, depression, or problems at home or school?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

4. Do you think smoking, drinking, or drugs are a problem for anyone in your family?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

5. Is your child exposed to violence in your home or community?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

6. What are some of your child’s strengths and talents?___________________________________________

7. Would you like help with talking to your child about puberty, menstrual periods, sex, drugs, alcohol, smoking,  
bullying or any other social issues?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

8. Is there anything you would like to discuss with the nurse or doctor today?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

9. Can we share your answers to any of the questions above with your child?  
☐ Yes  ☐ No  
*Please describe:___________________________________________________________

10. Primary Care Physician:_________________________________________  Phone:_________________________

11. Who referred you? Name:_________________________________________  Phone:_________________________

12. List other doctors or mental health counselors your child has seen in the last year:

   Name:_________________________________________  Phone:_________________________
   Name:_________________________________________  Phone:_________________________
   Name:_________________________________________  Phone:_________________________
Are You Getting Enough CALCIUM?

Name: __________________________________________  Date: ___________  Age: _________

1. On average, how many 8 oz. glasses of milk (whole, reduced-fat, skim, or lactose-free) do you drink?
   ☐ less than one glass per day  ☐ 1 glass per day
   ☐ 2 glasses per day  ☐ more

2. On average, how often do you eat a serving (1/2 cup, cooked) of deep-green vegetable (broccoli, kale, collard greens, etc.)?
   ☐ daily  ☐ 3X a week  ☐ weekly  ☐ never

3. On average, how often do you eat a serving (1 oz.) of hard cheese (Parmesan, Cheddar, Swiss, etc.)?
   ☐ daily  ☐ 3X a week  ☐ weekly  ☐ never

4. On average, how often do you eat a serving (1 cup) of yogurt?
   ☐ daily  ☐ 3X a week  ☐ weekly  ☐ never

5. On average, how often do you eat a serving (1/2 cup; approximately 1 large scoop) of premium or low-fat ice cream?
   ☐ daily  ☐ 3X a week  ☐ weekly  ☐ never

6. How often do you eat any calcium-fortified foods such as cereals, juice, cottage cheese, or breakfast bars?
   ☐ daily  ☐ 3X a week  ☐ weekly  ☐ never

7. On average, how often do you eat a serving (3 oz.) of canned salmon or sardines (including bones)?
   ☐ daily  ☐ 3X a week  ☐ weekly  ☐ never

8. How many alcoholic beverages do you have in an average day?
   (One alcoholic beverage = 5 oz. of wine, 12 oz. of beer, 1.5 oz. of hard liquor)
   Wine: ☐ 1 ☐ 2 ☐ More  Beer: ☐ 1 ☐ 2 ☐ More
   Liquor: ☐ 1 ☐ 2 ☐ More

9. Do you take any multivitamin supplements?  ☐ Yes  ☐ No

10. Do you take a calcium supplement?  ☐ Yes  ☐ No
    If yes, what type?____________________  No. Tabs/Day _________

Calculating Calcium Intake

Using the answers to the questionnaire on the left, multiply the number of servings for each question by the number of milligrams provided then add it up for an estimated calcium intake.

1. No. of glasses x 300 __________
2. No. of servings x 150 __________
3. No. of ounces x 200 __________
4. No. of cups x 400 __________
5. No. of ½ cups x 85 __________
6. No. of servings x 200 __________
7. No. of servings x 150 __________
8. No. of servings x 150 __________
9. No. of tabs x mg/tab __________
10. No. of tabs x mg/tab __________

DAILY TOTAL __________
### Are You Getting Enough Calcium?

Where you’ll find it...

#### Age Group | Suggested daily calcium intake
---|---
**Infants**
(Birth to 6 months) | 210 milligrams
(7 months to 1 year) | 270 milligrams

**Children**
(1 to 3 years) | 500 milligrams
(4 to 8 years) | 800 milligrams

**Teens and young adults**
(9 to 18 years) | 1,300 milligrams

| Adults | Suggested daily calcium intake |
---|---|
**Women**
(31 to 50 years) | 1,000 milligrams
(51 years and older) | 1,200 milligrams

**Postmenopausal Women**
(on estrogen) | 1,200 milligrams
(not on estrogen) | 1,500 milligrams

**Pregnant/Lactating Women**
(all ages) | 1,200 milligrams

| Food Items | Milligrams |
---|---|
**Milk**
Milk (2%), 8 ounces | 315 milligrams
Milk (Skim), 8 ounces | 302 milligrams
Milk (Whole), 8 ounces | 291 milligrams
Low-fat Chocolate, 8 ounces | 287 milligrams
Buttermilk, 8 ounces | 285 milligrams
Breast milk, 8 ounces | 79 milligrams

**Yogurt**
Nonfat yogurt, 8 ounces | 452 milligrams
Low-fat yogurt, 8 ounces | 415 milligrams
Yogurt with fruit, 8 ounces | 345 milligrams
Yogurt Drink, 8 ounces | 186 milligrams
Frozen yogurt, ¼ cup | 90 milligrams

**Cheese**
Goat cheese (hard), 1 ounce | 254 milligrams
Part-skim mozzarella, 1 ounce | 183 milligrams
American cheese, 1 ounce | 174 milligrams
Low-fat cottage cheese, 1 cup | 155 milligrams
Feta cheese, 1 ounce | 140 milligrams
Grated parmesan cheese, 1 tbs. | 69 milligrams

**Fish**
Sardines with bones, 3 ounces | 370 milligrams
Canned salmon with bones, 3 ounces | 180 milligrams

**Vegetables**
Collards, 1 cup | 357 milligrams
Turnip greens, 1 cup | 200 milligrams
Kale, 1 cup | 179 milligrams
Broccoli (cooked), 1 cup | 178 milligrams
Okra (cooked), 1 cup | 176 milligrams
Dandelion greens, 1 cup | 147 milligrams
Mustard greens, 1 cup | 103 milligrams

**Other**
Vegetable lasagna, 1 piece | 450 milligrams
Orange-juice, 8 ounces | 300 milligrams
Cheese pizza, 1 slice | 290 milligrams
Chocolate pudding, ½ cup | 161 milligrams
Rice pudding, ½ cup | 152 milligrams
Vanilla ice-cream, ½ cup | 113 milligrams
Chocolate ice-cream, ½ cup | 106 milligrams