PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:_____ REFERRED BY:_____ SEX:_____

NAME:_____ BIRTHDATE:_____
LAST FIRST MIDDLE

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE:_____ CELL PHONE:_____ WORK NUMBER:_____

SS #_____ MARITAL STATUS:_____ EMAIL:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

****

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:_____

****

NEXT OF KIN:_____ BIRTHDATE:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

SS #:_____ BIRTHDATE_____ TELEPHONE:_____

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PRIMARY INSURANCE:_____ ID#:_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

SECONDARY INSURANCE:_____ ID#_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

SIGNATURE:_____ DATE:_____

Gynecologic Intake History

Name:	**Date:**	**DOB:**

Reason for visit:

OB/GYN History (Please list any complications) Date of last Menstrual period _____ Date of last Pap Smear _____	Date of last Mammogram _____ Date of last DEXA/Bone density _____
# of Births _____ # of Pregnancies _____	# of Abortions _____ # of Living Children _____

What method do you use for birth control? (Example: birth control pills, tubal, etc.)

☐ Anemia	☐ Fracture	☐ Seizures/Convulsions
☐ Arthritis/Joint Pain	☐ Heart Trouble/Murmur	☐ Stroke
☐ Asthma	☐ Hepatitis	☐ Thyroid Disease
☐ Cancer	☐ High Blood Pressure	☐ Tuberculosis
☐ Chronic Lung Disease	☐ Kidney Infections/Stones	☐ Ulcers
☐ Diabetes	☐ Pneumonia	☐ Venereal Disease

SURGICAL AND HOSPITALIZATION HISTORY

Date	Type of Surgery/Hospital Stay

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: _____

	Age	**State of Health**	**Age at Death**	**Cause of Death**		**Age**	**State of Health**	**Age at Death**	**Cause of Death**
Father					Mother				
Brothers					Sisters				

Check (✓) if your blood relatives had any of the following.

☐ Arthritis, Gout	☐ Diabetes	☐ Ovarian Cancer	☐ Other _____
☐ Breast Cancer	☐ Heart Disease	☐ Stroke	☐ Other _____
☐ Colon Cancer	☐ High Blood Pressure	☐ Tuberculosis	☐ Other _____

Check (✓) which substances you use and indicate how much you use per day/week.	Do you exercise regularly? ☐ yes ☐ no	Any abuse or violence? ☐ yes ☐ no
Caffeine Tobacco	Have you ever used street drugs? ☐ yes ☐ no	Any sexual problems? ☐ yes ☐ no
Drugs Alcohol	Any family problems? ☐ yes ☐ no	

Medicare "High Risk" Criteria	
Have you been treated for Vaginosis, Genital Warts, Chlamydia, Herpes, or Trichomonas?	☐ yes ☐ no
Have you had a Pap Smear in the last 7 years?	☐ yes ☐ no
Have you had an abnormal Pap Smear within the last 7 years?	☐ yes ☐ no
Did you begin sexual activity before you were 16 years old?	☐ yes ☐ no
Have you had more than 5 sexual partners in your lifetime?	☐ yes ☐ no
Have you ever tested positive for the HIV virus?	☐ yes ☐ no
Did your mother take the drug DES when she was pregnant with you?	☐ yes ☐ no

Gynecologic Intake History

Name:	**Date:**	**DOB:**

List All Current Medications (or provide a list)

REVIEW OF SYSTEMS (Check (✓) the medical conditions you have or have had in the past year.

Constitutional	**Respiratory**	**Musculoskeletal**	**Hematologic/Lymphatic**
☐ Weight loss-intentional/unintentional	☐ Wheezing	☐ Muscle weakness	☐ Frequent bruising
☐ Weight gain-rapid/gradual	☐ Spitting up blood	☐ Muscle aches	☐ Enlarged lymph nodes
☐ Fever	☐ Shortness of breath	**Skin/Breast**	**Allergic/Immunologic**
☐ Fatigue	☐ Chronic cough	☐ Pain in breast	☐ Seasonal allergies
Eyes	**Gastrointestinal**	☐ Discharge	☐ Drug allergies
☐ Double Vision	☐ Diarrhea (frequent)	☐ Masses	
☐ Spots before eyes	☐ Bloody stool	☐ Rash	**List allergies & reactions**
☐ Vision changes	☐ Nausea	☐ Breast tenderness	1.
ENT/Mouth	☐ Vomiting	**Neurological**	2.
☐ Ear aches	☐ Constipation	☐ Dizziness	3.
☐ Ringing in ears	**Genitourinary**	☐ Seizures	4.
☐ Sinus problems	☐ Blood in urine	☐ Numbness	5.
☐ Sore throat	☐ Painful urination	**Psychiatric**	6.
☐ Mouth sores	☐ Urgency	☐ Depression	7.
Cardiovascular	☐ Frequent urination	☐ Anxiety	8.
☐ Painful breathing	☐ Stress incontinence	☐ Frequent crying	9.
☐ Chest pain	☐ Abnormal periods	**Endocrine**	10.
☐ Difficulty breathing on exertion	☐ Painful intercourse	☐ Dry skin	11.
☐ Swelling of legs	☐ Pelvic pain	☐ Abnormal thirst	12.
☐ Palpitations of heart	☐ Vaginal discharge	☐ Hot flashes	13.

Patient Signature:_____ Date:_____

Completed by: ☐ Patient ☐ Office Nurse ☐ Physician

Reviewed by:_____ Date:_____

Annual review of history

Date reviewed:	Provider signature:
Date reviewed:	Provider signature:
Date reviewed:	Provider signature:
Date reviewed:	Provider signature:
Date reviewed:	Provider signature: