SOUTHEAST OBSTETRICS AND GYNECOLOGY, PC

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PATIENT INFORMATION:

DATE OF VISIT:_____

PATIENT NAME: _____ BIRTH DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
SOCIAL SECURITY #_____ MARITAL STATUS _____
HOME PHONE: _____ CELL PHONE: _____
RACE: _____ ETHNICITY: _____ LANGUAGE: _____
E-MAIL: _____ EMPLOYER: _____
WORK PHONE: _____ OCCUPATION: _____
MAY WE CONTACT YOU AT ALL THE NUMBERS ABOVE? YES____ NO ____
IF NO PLEASE SPECIFY WHERE WE CANNOT CONTACT YOU: _____
SPOUSE NAME: _____ PHONE: _____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____
FAMILY DOCTOR NAME: _____
REFERRING DOCTOR: _____ OB/GYN: _____

INSURANCE INFORMATION:

INSURANCE COMPANY: _____ EFFECTIVE DATE: _____
POLICY NUMBER: _____ INS CO. PHONE: _____
ADDRESS: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY: _____ RELATIONSHIP TO PATIENT: _____

PERSON RESPONSIBLE FOR PAYMENT (if other than patient):

NAME: _____ DATE OF BIRTH: _____ SS#: _____
ADDRESS: _____
PHONE: _____ CELL: _____ WORK: _____
EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____ RELATIONSHIP TO PATIENT: _____

PHOTO ID CHECKED ____ DATE: _____ INITIALS _____

PLEASE TURN OVER

SOUTHEAST OBSTETRICS AND GYNECOLOGY, P.C.
CONFIDENTIAL PATIENT HISTORY

(Rev. 10/09)

The information on this form is intended to help the physician with your diagnosis and treatment. Please complete both sides of the form as fully as possible.

Name_____ Phone #_____ Date_____

Birth Date_____ Age_____ Marital Status: S M Sep W D

Primary Care Provider_____ PCP Office Location_____

FAMILY HISTORY:

☐ No ☐ Yes Are you adopted?

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or MGF - Maternal or Paternal)

No	Yes		Who	No	Yes		Who	No	Yes		Who
☐	☐	Diabetes		☐	☐	High cholesterol		☐	☐	Breast cancer	
☐	☐	Heart disease		☐	☐	Thyroid disease		☐	☐	Ovarian cancer	
☐	☐	Lung disease		☐	☐	Osteoporosis		☐	☐	Uterine cancer	
☐	☐	Depression		☐	☐	Sickle-Cell disease		☐	☐	Cervical cancer	
☐	☐	High blood pressure		☐	☐	Arthritis		☐	☐	Colon cancer	
☐	☐	Stroke		☐	☐	Other hereditary diseases		☐	☐	Other cancers	

MEDICAL HISTORY/REVIEW OF SYSTEMS:

Do you have, or have you ever had, any of the following:

Yes	Now		No	Yes	Now		No	Yes	Now	
☐	☐	Weight gain/loss >10 lbs	☐	☐	☐	Breast disease	☐	☐	☐	Kidney problem
☐	☐	Marked fatigue	☐	☐	☐	Diabetes	☐	☐	☐	Bladder infection
☐	☐	Hearing loss	☐	☐	☐	Thyroid problem	☐	☐	☐	Stomach/bowel problem
☐	☐	Sinus problems	☐	☐	☐	Depression/anxiety	☐	☐	☐	Liver disease
☐	☐	Heart disease	☐	☐	☐	Numbness or tingling of extremities	☐	☐	☐	Shortness of breath
☐	☐	Lung disease					☐	☐	☐	Arthritis
☐	☐	Chest pain	☐	☐	☐	Epilepsy/seizures	☐	☐	☐	Toxic work exposure
☐	☐	Palpitations	☐	☐	☐	Stroke	☐	☐	☐	Skin problems
☐	☐	High blood pressure	☐	☐	☐	Headaches	☐	☐	☐	Asthma
☐	☐	Varicose veins	☐	☐	☐	Difficulty swallowing	☐	☐	☐	Blood clots
☐	☐	Anemia	☐	☐	☐	Bleeding disorders	☐	☐	☐	Other illness (list type)
☐	☐	Cancer, Type_____	☐	☐	☐	Osteoporosis				

MEDICATIONS

Please list all medications you are using by name and dosage (include vitamins and herbs)

_____

_____

_____

_____

_____

Birth control_____

ALLERGIES

Are you allergic to (circle): Latex Iodine/Shellfish

Allergies to medications: Please list drug and reaction:

_____

_____

_____

_____

_____

_____

SURGICAL/HOSPITALIZATION HISTORY

Please list the date and type of surgery or reason for hospitalization:

Date	Type	Date	Type

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(Rev. 09/09)

Name_____ DOB_____

PREGNANCY HISTORY

Date of Pregnancies (date of delivery, loss, or termination)	Type of Delivery (vaginal/c-section/loss)	Complications	Sex

GYN/MENSTRUAL HISTORY

Age period started_____ LMP_____
Periods come every_____days and last for_____ days
Periods are: ☐ regular ☐ irregular ☐ light ☐ moderate ☐ heavy

☐ No ☐ Yes Are you sexually active? Your partner is: ☐ Male ☐ Female

Do you have now, or have you ever had problems with the following:

No Yes Now
- ☐ ☐ ☐ Severe cramps with your period
- ☐ ☐ ☐ Bleeding between periods
- ☐ ☐ ☐ Vaginal discharge/infection
- ☐ ☐ ☐ STD (sexually transmitted disease):
  - ☐ syphilis ☐ gonorrhea ☐ trichomonas
  - ☐ chlamydia ☐ herpes ☐ genital warts ☐ HIV
- ☐ ☐ ☐ Abnormal Pap smears
- ☐ ☐ ☐ Abnormalities of the uterus
- ☐ ☐ ☐ Tumors/cysts of ovaries
- ☐ ☐ ☐ Infertility/Endometriosis
- ☐ ☐ ☐ Sexual difficulty
- ☐ ☐ ☐ Pain/bleeding with intercourse
- ☐ ☐ ☐ Bothersome loss of urine

WELLNESS/SCREENING

	Date of last test/immunization:
Pap smear	
Mammogram	
Bone density	
Cholesterol	
Colonoscopy or Sigmoidoscopy	
Fecal Occult Blood cards	
Tetanus shot	
Pneumonia Vaccine	

☐ No ☐ Yes Do you have a health care proxy?
☐ No ☐ Yes Do you perform self breast exams monthly?
☐ No ☐ Yes Do you exercise? Type & frequency:_____

☐ No ☐ Yes Do you get enough calcium (1200 mg)?
☐ No ☐ Yes Do you always wear your seat belt?
☐ No ☐ Yes Are you current with dental care?
☐ No ☐ Yes Are you on any particular diet?
☐ No ☐ Yes 3 Gardasil Vaccinations completed (if < age 27?

SOCIAL HISTORY

Circle the highest year of school completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 >17 Degree_____

Occupation_____Employer_____

- ☐ ☐ Yes ☐ Caffeine: Average amount /day_____
- ☐ ☐ Yes ☐ Tobacco: If Yes, _____packs/day for how many years_____
- No ☐ Yes ☐ Street drugs: what?_____
- No ☐ Yes ☐ Alcohol: # drinks per day (beer, wine, liquor)_____
- No ☐ Yes ☐ History of physical or sexual abuse?

TODAY'S VISIT

What concerns or problems would you like to discuss today?

_____

_____

Are you interested in?:
- No ☐ Yes ☐ HIV (AIDS) testing?
- No ☐ Yes ☐ Other STD testing?
- No ☐ Yes ☐ Chaperone with exam

Patient's Signature_____ Date_____

OFFICE USE ONLY:
I have reviewed the above and personally discussed this with the patient._____ MD Date_____