Name (First, Middle, Last)

Responsible Party or Parents Name (if minor)

Address

City State Zip

Sex: ☐ M ☐ F

Date of Birth Age

Social Security Number

Cell Phone Home Phone

Email

Employer or Parent Occupation Work Phone

Marital Status: ☐ S ☐ M ☐ D ☐ W

SPOUSE INFORMATION

Name

Employer

Work Phone

Cell

Email

RACE

- ☐ American Indian or Alaska Native
- ☐ Black or African
- ☐ American Native
- ☐ Hawaiian or other Pacific Islander
- ☐ White

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name Relationship

Address City State Zip

Phone (Day) Phone (Evening) Cell Email

REFERRING DOCTOR/SOURCE:

Please present your insurance card to the receptionist.

PRIMARY INSURANCE CARRIER

Insurance Company Name

Insurance Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Dependent

SECONDARY INSURANCE CARRIER

Insurance Company Name

Insurance Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Dependent

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature Date

DATE: **NAME:** **DATE OF BIRTH:**

REASON FOR VISIT:

HERE FOR ANNUAL EXAM: YES NO

LAST MENSES: LAST PAP: LAST MAMMO: LAST COLONOSCOPY:

PRIMARY CARE DR: COPY OF RESULTS TO PRIMARY/REFERRING DR: YES NO

REFERRED BY:

ALLERGY TO MEDICATION: NONE KNOWN YES: _____

CURRENT/RECENT MEDICATIONS (INCL. SUPPLEMENTS AND VITAMINS:

PAST MEDICAL HISTORY (please circle): NONE

Abnormal Pap	Anxiety/Depression	Anemia	Asthma
Cancer	Deep Vein Thrombosis	Diabetes	Ectopic Pregnancy
Endometriosis	Fibroids	Gastritis	Headaches
Hypertension	High Cholesterol	PCOS	Osteoporosis
Stroke	Thyroid Disease	Urinary Infections	
Other:			

OPERATIONS (please describe):

DATE	DATE

FAMILY HISTORY Do any of your **FAMILY** members have any of the following illnesses?

ILLNESS	Yes/No	FAMILY MEMBER	ILLNESS	Yes/No	FAMILY MEMBER
Diabetes			Breast Cancer		
Heart Disease			Ovarian Cancer		
Hypertension			Colon Cancer		
Deep Vein thrombosis			Other Cancer		
Other:					

SOCIAL HISTORY Personal habits

Do you smoke?	Yes	No	Former	Packs per day:	Years:
Do you drink?	Yes	No	Drinks per week:		
Do you use any drugs?	Yes	No	Name of drugs:		
Do you drink caffeine?	Yes	No	Cups per day:		

SOCIAL HISTORY Personal profile

Relationship status: Single In a relationship Divorced Widowed

Number of living children:

Number of people in household:

School completed: High school College Graduate Degree

Current or most recent job:

MENSTRUAL HISTORY

How often do you get menses?

How long does your period last?

On your heaviest day, how many pads/tampons do you use?

Is your period painful? Yes No

Menopausal? Yes No

SEXUAL HISTORY

Are you sexually active? Yes No

Who are you active with? Men Women Both

Trying to get pregnant? Yes No

Are you sexually active? Yes No

What are you using to prevent pregnancy?

What are you using to prevent STDs?

History of any STDs? Yes No

History of abnormal pap? Yes No

Did you get the HPV vaccine? Yes No

PREGNANCY HISTORY

Number Of Pregnancies: Miscarriages: Terminations: Deliveries:

DATE	WEEKS	LABOR LENGTH	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	ANESTHESIA	DELIVERY PLACE	DELIVERY COMPLICATIONS

REVIEW OF SYSTEMS Please **CIRCLE** and describe any that apply to you now or recently

CONSTITUTIONAL
Weight loss
Weight gain
Fatigue
Change in appetite
Mood change
Difficulty sleeping
Hot flashes

HEAD/EARS/NOSE/THROAT/MOUTH
Vision changes
Ringing in ears
Hearing loss
Sinus problems
Sore throat
Mouth sores

CARDIOVASCULAR/RESPIRATORY
Chest pain
Shortness of breath
Difficult breathing on exertion
Swelling of legs
Palpitations of heart
Fainting
Wheezing
Chronic cough

BREAST
Pain in breast
Discharge from nipple
Breast lump
Skin changes

GASTROINTESTINAL
Abdominal pain
Nausea/vomiting
Frequent diarrhea
Constipation
Blood in stool

GENITOURINARY
Losing control of urine
Urinary urgency
Frequency of urination
Night-time urination
Difficulty urinating
Incomplete emptying
Blood in urine
Pain with urination
Pelvic pain
Lumps/growths
Irregular periods
Painful periods

GENITOURINARY CONTINUED
Heavy periods
Itching
Odor
Genital sores
Vaginal discharge
Vaginal dryness
Painful sex
Bleeding with sex

MUSCULOSKELETAL
Muscle weakness

ALLERGIC/IMMUNOLOGIC
Latex allergy
Environmental allergies
Immunodeficiency