Affiliates in OB/GYN **ACCOUNT #:**

Gynecology Questionnaire

Name:_____

LAST FIRST MAIDEN

HomeAddress:_____

HOUSE /APT. # STREET TOWN STATE ZIP CODE

Date of Birth:_____/_____/_____ **Social Security #:**_____-_____-_____

Home Phone:_____**CellPhone:**_____**WorkPhone:**_____ext._____

Is it OK to leave messages on Home/Cell #'s: ▫ YES ▫ NO *OK to Call Work:* ▫ YES ▫ NO

Email Address*: _____**Language spoken at home:**_____**Race:**_____
***WOULD YOU LIKE TO PARTICIPATE IN OUR PATIENT PORTAL? ( ) YES ( ) NO**

Employer/School Name:_____**Occupation:**_____

Marital Status: ☐MARRIED ☐DIVORCED ☐WIDOWED ☐ SINGLE ☐ SEPARATED ☐PARTNERED

Spouse/Partner Name:_____**Spouse/Partner Occupation:**_____

Emergency Contact Name:_____**Relationship to Patient:**_____

Emergency Contact Phone #:_____

➜If patient is a minor, to whom are we allowed to release information to:

Parent/Guardian Name(s):_____**Relationship to Patient:**_____

Parent/Guardian Address:_____**Parent/Guardian Phone**:_____

INSURANCE INFORMATION:

Insurance Name:_____**ID#:**_____**Group#:**_____

Subscriber Name:_____**DOB:**_____/_____/_____**SS#:**_____-_____-_____

Subscriber Address:_____**Relationship to Patient:**_____

Subscriber Employer:_____

Medical Information Release/Medical Examination Consent

I understand insurance is a contract between myself, the insurance company, and/or my employer. I am responsible for knowing policy benefits, restrictions, and covered services. All co-pays are due at time of service. I also understand the it is my responsibility to provide current insurance information to the practice.I understand and agree that, regardless of insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I hereby authorize the practice to release medical information regarding my care in order to process any claims. I hereby give consent to a medical exam:

Signature:_____**Date:**_____

Reason for Today's Visit:_____

Pharmacy:_____**Location:**_____ **Primary Care Doctor:**_____**Phone:**_____

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MEDICAL HISTORY: DO YOU NOW HAVE OR HAVE YOU EVER HAD:

( ) Asthma

( ) Auto-immune disorder

( ) Bleeding disorder

( ) Blood transfusion date:_____

( ) Cancer type:_____

( ) Chicken Pox/Shingles

( ) Deep Vein Thrombosis

( ) Depression

( ) Diabetes

( ) Elevated Cholesterol

( ) Endometriosis

( ) Fibroids

( ) G.I. Illness:_____

( ) Heart Disease:_____

( ) Hepatitis

( ) Herpes

( ) HIV

( ) High Blood Pressure

( ) Thyroid

( ) Liver Disease

( ) Migraines

( ) Osteopenia

( ) Osteoporosis

( ) Pelvic Inflammatory Disease

( ) Seizures

( ) Sleep Apnea

FAMILY HISTORY: Check in box with coordinating family member:

Illness	Breast Cancer	Pelvic Cancer	Other Cancer	Diabetes	Hyper-tension	Depression	Thyroid Disease	Osteoporosis /Osteopenia
Parent								
Sibling								
Grand-parent								
Other								

MEDICATION LIST:

Medication	Dosage	Medication	Dosage

ALLERGIES:

Medication	Reaction	Medication	Reaction

SURGICAL HISTORY:

Surgery Type	Date of Surgery	Surgery Type	Date of Surgery

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***Complication with Anesthesia? YES/NO explain:**_____

Well Woman Update:

Last Bone Density/DEXA?_____	Result:_____	History of Abnormal Pap? YES/NO	Treatment? YES/NO Date:_____
Last Colonoscopy?_____	Result:_____	History of STD? YES/NO?	Type:_____
Last Mammogram?_____	Result:_____	Do you Smoke? YES/NO In Past? YES/NO Date Stopped:	# of cigarettes per day:_____
Last PAP Smear?_____	Result:_____	Do you drink Alcohol? YES/NO	# of drinks per day:_____
HPV/Gardasil Vaccine? YES/NO		Do you drink Caffeine? YES/NO	# of drinks per day:_____
Do you use drugs? YES/NO	Type:_____	Do you take Calcium? YES/NO	How much?_____
Past history of drug use? YES/NO	Date Stopped: _____	Do you take Vitamin D? YES/NO	How much?_____
Do you exercise? YES/NO	Type:_____		

Reproductive History:

Age at 1st period?_____ Age at Menopause?_____

How often do you get your menstrual cycle? Every_____days, lasting_____days.

Are your cycles ? CHECK ALL THAT APPLY ( ) Regular ( ) Irregular ( ) Heavy ( ) Moderate ( ) Light ( ) Painful

METHOD OF CONTRACEPTION:

( ) None ( ) Vasectomy ( ) Rhythm Method ( ) Tubal Ligation ( ) Mirena IUD ( ) Paragard IUD ( ) Condoms

( ) Nuvaring ( ) Depo Provera ( ) Pill Brand:_____Date Started:_____ ( ) Other

PAST PREGNANCIES: TERM:_____ PRETERM:_____ MISCARRIAGE:_____ ECTOPIC:_____ TERMINATION:_____

Complication with Pregnancies? YES/NO explain:_____ History of Cesarean Section? YES/NO

How did you hear about our Practice? ( ) Advertisement ( ) Internet ( ) Other **Referral from:**_____

By signing below I understand that during the course of your evaluation and treatment lab work, including but not limited to PAPS, bloodwork and ultrasound examinations may be ordered. It is impossible for us to know all the restrictions and benefits of your insurance policy. You are responsible to know what is covered and not covered by your insurance policy and will be billed for any denial in coverage or for any balance not paid by your insurance company. If you have questions about your policy, contact your insurance company.
I certify this information is true and correct to the best of my knowledge.

Patient Signature:_____**Date:**_____