

PATIENT INFORMATION

Chart #:

PATIENT	Mr. Mrs. Miss/Ms. Last	First	MI	HOME PHONE:
Patient's Home Address		City	State	Zip
Social Security #	Date of Birth	Age	Sex	Driver's License #
Patient's Employer	Work Address	Work Phone:	Occupation:	
Spouse's Name	Spouse's Employer (Name & Address)			Work Phone:
Friend Name	Address			Phone:

REFERRED TO THIS OFFICE BY: _____

PURPOSE OF THIS VISIT? _____

INSURANCE	PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES WHICH COVER THIS PATIENT:
<p>PRIMARY: Insured Name _____ Policy # _____ Subscriber SS _____</p> <p>Insurance Name _____ Phone _____</p> <p>Billing Address: _____ City: _____ State: _____ Zip: _____</p>	
<p>SECONDARY: Insured Name _____ Policy # _____ Subscriber SS _____</p> <p>Insurance Name _____ Phone _____</p> <p>Billing Address: _____ City: _____ State: _____ Zip: _____</p>	
FOR OFFICE USE ONLY	<p>YRLY DEDCTBL: _____ DEDCTBL BLNCE: _____ % OF REIMBURSEMENT: _____ / _____ EFF: _____</p> <p>MAXIMUM OF BENEFITS: _____ STOP LOSS OUT OF POCKET: _____ PRE-EXISTING POLICY: _____</p> <p>DATE: _____ PRE-CERT REQ IN' OUT: _____ OFFICE VISIT CO-PAYMENT: _____ SPOKE TO: _____</p>
NOTES: _____	

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 you insurance.

METHOD OF PAYMENT: CASH: _____ CHECK: _____ CREDIT CARD: _____

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to _____
 And understand that i am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE:

FOR OFFICE USE ONLY
 NEW PATIENT
 ESTABLISHED PATIENT
 CONSULTATION
 REPORT SENT:

PATIENT INTAKE HISTORY

DATE:

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO REGULAR BREAST SELF-EXAMINATIONS?	

PATIENT INTAKE HISTORY (Continued)

OBSTETRIC HISTORY

		NUMBER			NUMBER			NUMBER
PREGNANCIES			ABORTIONS			MISCARRIAGES		
PREMATURE BIRTHS (<37 WEEKS)			LIVE BIRTHS			LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?		
1.								
2.								
3.								
4.								
PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:								

CURRENT MEDICATIONS
(including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED CAUSE:		AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED CAUSE:		AGE:
SIBLINGS: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
CHILDREN: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET		PHYSICIAN'S NOTES	
DIABETES	<input type="checkbox"/>				
STROKE	<input type="checkbox"/>				
HEART DISEASE	<input type="checkbox"/>				
BLOOD CLOTS IN LUNGS OR LEGS	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>				
HIGH CHOLESTEROL	<input type="checkbox"/>				
OSTEOPOROSIS (WEAK BONES)	<input type="checkbox"/>				
HEPATITIS	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>				
TUBERCULOSIS	<input type="checkbox"/>				
BIRTH DEFECTS	<input type="checkbox"/>				
DRINKING OR DRUG PROBLEMS	<input type="checkbox"/>				
BREAST CANCER	<input type="checkbox"/>				
COLON CANCER	<input type="checkbox"/>				
OVARIAN CANCER	<input type="checkbox"/>				
UTERINE CANCER	<input type="checkbox"/>				
MENTAL ILLNESS/DEPRESSION	<input type="checkbox"/>				
ALZHEIMER'S DISEASE	<input type="checkbox"/>				
OTHER	<input type="checkbox"/>				

PATIENT INTAKE HISTORY (Continued)

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	<input type="checkbox"/>	<input type="checkbox"/>	
RECREATIONAL DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH HAZARDS AT HOME OR WORK?	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PROFILE

SEXUAL ORIENTATION: <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> BISEXUAL
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LIVING WITH PARTNER <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> SOME COLLEGE/AA DEGREE <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE DEGREE <input type="checkbox"/> OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE U.S.? LOCATION:

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA		<input type="checkbox"/>	<input type="checkbox"/>	
PNEUMONIA/LUNG DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
KIDNEY INFECTIONS/STONES		<input type="checkbox"/>	<input type="checkbox"/>	
TUBERCULOSIS		<input type="checkbox"/>	<input type="checkbox"/>	
SEXUALLY TRANSMITTED DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>	
HEART ATTACK/PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
DIABETES		<input type="checkbox"/>	<input type="checkbox"/>	
HIGH BLOOD PRESSURE		<input type="checkbox"/>	<input type="checkbox"/>	
STROKE		<input type="checkbox"/>	<input type="checkbox"/>	
RHEUMATIC FEVER		<input type="checkbox"/>	<input type="checkbox"/>	
BLOOD CLOTS IN LUNGS OR LEGS		<input type="checkbox"/>	<input type="checkbox"/>	
EATING DISORDERS		<input type="checkbox"/>	<input type="checkbox"/>	
COLLAGEN VASCULAR DISEASE (LUPUS)		<input type="checkbox"/>	<input type="checkbox"/>	
CHICKENPOX		<input type="checkbox"/>	<input type="checkbox"/>	
CANCER		<input type="checkbox"/>	<input type="checkbox"/>	
REFLUX/HIATAL HERNIA/ULCERS		<input type="checkbox"/>	<input type="checkbox"/>	
DEPRESSION/ANXIETY		<input type="checkbox"/>	<input type="checkbox"/>	
ANEMIA		<input type="checkbox"/>	<input type="checkbox"/>	
BLOOD TRANSFUSIONS		<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES/CONVULSIONS/EPILEPSY		<input type="checkbox"/>	<input type="checkbox"/>	
BOWEL PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
GLAUCOMA		<input type="checkbox"/>	<input type="checkbox"/>	
CATARACTS		<input type="checkbox"/>	<input type="checkbox"/>	
ARTHRITIS/JOINT PAIN/BACK PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
BROKEN BONES		<input type="checkbox"/>	<input type="checkbox"/>	
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
THYROID DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT INTAKE HISTORY (Continued)

PERSONAL PAST HISTORY OF ILLNESSES (Continued)

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
HEADACHES		<input type="checkbox"/>	<input type="checkbox"/>	
OTHER		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA VACCINE		PNEUMOCOCCAL VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	

PHYSICIAN'S NOTES:

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
WEIGHT GAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHANGE IN HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT INTAKE HISTORY (Continued)

REVIEW OF SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
2. EYES				
DOUBLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPOTS BEFORE EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VISION CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. EAR, NOSE, AND THROAT				
EARACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RINGING IN EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORE THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR				
PAINFUL BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHEST PAIN OR PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIFFICULTY BREATHING ON EXERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SWELLING OF LEGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RAPID OR IRREGULAR HEARTBEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY				
WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPITTING UP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAUSEA/VOMITING/INDIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY LOSS OF GAS OR STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARY				
BLOOD IN URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAIN WITH URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STRONG URGENCY TO URINATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INCOMPLETE EMPTYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY/UNINTENDED URINE LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
URINE LOSS WHEN COUGHING OR LIFTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PREMENSTRUAL SYNDROME (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL INTERCOURSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FIBROIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INFERTILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DES EXPOSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT INTAKE HISTORY (Continued)

REVIEW OF SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
B. MUSCULOSKELETAL (Continued)				
MUSCLE OR JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9a. SKIN				
RASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRY SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9b. BREASTS				
PAIN IN BREAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NIPPLE DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGIC				
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TROUBLE WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE MEMORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT OR SEVERE HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I 1. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINE				
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEAT/COLD INTOLERANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL THIRST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HOT FLASHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CUTS DO NOT STOP BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENLARGED LYMPH NODES (GLANDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
OTHER ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				
FORM COMPLETED BY: <input type="checkbox"/> PATIENT <input type="checkbox"/> OFFICE NURSE <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OTHER:				
SIGNATURE OF PATIENT:				
DATE REVIEWED BY PHYSICIAN WITH PATIENT:			PHYSICIAN SIGNATURE:	
ANNUAL REVIEW OF HISTORY				
DATE REVIEWED:			PHYSICIAN SIGNATURE:	
DATE REVIEWED:			PHYSICIAN SIGNATURE:	
DATE REVIEWED:			PHYSICIAN SIGNATURE:	
DATE REVIEWED:			PHYSICIAN SIGNATURE:	