B-C OBGYN, LLC Patient Information

Name:____Age:____ Birth Date:______________________
Last First MI

Address:____________________________________City:__________________State:____ Zip:________________

Home Phone:__________________Cell Phone:__________________E-Mail Address:__________________________

SSN:______________________________________Primary Care Physician: ______________________________

Pharmacy Name and Number:____

Employed? (circle one) Yes No **Full-time Student?** (circle one) Yes No

Employer:______________________________Work Phone:__________________Occupation:________________

Work Address:______________________________City:__________________State:_ Zip:________________

Marital Status (circle one) Single Married Divorced Widowed **Who referred you here?**______________________

SPOUSE or PARENT INFORMATION

Name:________________________Social Security Number:__________________________Birth Date: ______________

Employer:__________________________Work Phone:__________________Cell Phone:____________________

Work Address:______________________________City:__________________State:_ Zip:________________

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name:____Relationship:____________________________

Address:__________________________________City:____________________State:_ Zip:________________

Home Phone:____________________Work Phone:____________________Cell Phone:____________________

INSURANCE INFORMATION

Primary Insurance Co. Name:______________________Group#:__________________ID#____________________

Address: ______________________________City:____________________State:_ Zip:________________

Policy Holder's Name:______________________________Social Security Number:__________________________

Date of Birth:______________________________Relation to Patient (circle one) Self Spouse Mother Father Other

Secondary Insurance Co. Name:__________________________Group#:__________________ID#:________________

Address:__________________________________City:__________________State:_ Zip:________________

Policy Holder's Name:________________________________Social Security Number:__________________________

Date of Birth:______________________________Relation to Patient (circle one) Self Spouse Mother Father Other

I **authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered. I understand that I am financially responsible for all services rendered, that there is a $30 returned check fee and that 30% will be added to my balance if my account must be referred to an agency for collection. Additionally, I understand that if I am covered by an insurance that requires a referral number, <u>it is my responsibility to obtain that referral number prior to my visit.</u>**

______________________________ ____________________
(Patient's Signature) (Date)

B-C OBGYN, LLC
Medical History

NAME:______________________________ DATE:______________

DOB______________________Pharmacy____________________

REASON FOR VISIT: (If not routine, briefly describe main symptoms.) ______________________________

____

PAST MEDICAL HISTORY:

List all operations you have had.		List all illnesses you have had that required hospitalization.	
OPERATION	DATE	ILLNESS	DATE
A.		A.	
B.		B.	
C.		C.	
D.		D.	
E.		E.	
F.		F.	

Have you ever had? (Check yes or no and give dates.)

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	
( )	( )	Thyroid Disorder	
( )	( )	Pneumonia	
( )	( )	Tuberculosis	
( )	( )	Heart Murmur	
( )	( )	High Blood Pressure	
( )	( )	Rheumatic Fever	
( )	( )	Diabetes	
( )	( )	German Measles or Vaccine	
( )	( )	Anemia	
( )	( )	Convulsions or Seizures	
( )	( )	Ulcers	
( )	( )	I will accept blood products if necessary	

YES	NO	ILLNESS	DATE
( )	( )	Jaundice of Hepatitis	
( )	( )	Kidney Stones	
( )	( )	Kidney Infection	
( )	( )	Bladder Infection	
( )	( )	Genital Herpes	
( )	( )	Gonorrhea	
( )	( )	Syphilis	
( )	( )	Broken Bones	
( )	( )	Arthritis	
( )	( )	Mental Illness	
( )	( )	Serious Injury	
( )	( )	Blood Transfusion	

Please list any additional medical conditions or illnesses:

ILLNESS	DATE

REVIEW OF SYSTEMS:
Are you currently having or have you recently had any of these symptoms? (Check **"YES" or "NO")**

A. GENERAL

YES	NO	
( )	( )	Recent weight gain
( )	( )	Recent weight loss
( )	( )	Depression
( )	( )	Headaches
( )	( )	Eye pain
( )	( )	Spots in front of eyes
( )	( )	Double vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose bleeds

B. CHEST AND HEART

YES	NO	
( )	( )	Palpitation
( )	( )	Skipped or irregular heart beats
( )	( )	Chest discomfort on exertion
( )	( )	Chest pain with breathing
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Shortness of breath lying down
( )	( )	Coughing up blood

C. BREASTS

YES	NO	
( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Nipple discharge
( )	( )	Family history of breast cancer
( )	( )	Previous mammogram date ____________

D. GASTROINTESTINAL

YES	NO	
( )	( )	Change in bowel habits
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright blood in stools
( )	( )	Clay colored stools
( )	( )	Black stools
( )	( )	Abdominal pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up blood
( )	( )	Painful bowel movements
( )	( )	Nausea or vomiting

E. GENITO-URINARY

YES	NO	
( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Excessive urine
( )	( )	Frequent night urination
( )	( )	Change of color of urine
( )	( )	Blood or pus in urine
( )	( )	Wetting in bed

F. EXTREMITIES

YES	NO	
( )	( )	Varicose veins
( )	( )	Pain in legs when walking
( )	( )	Blood clots in legs
( )	( )	Skin rashes
( )	( )	New or growing moles

B-C OBGYN LLC
Medical History (Sheet 2)

NAME: ....

MEDICATIONS: (List **ALL** medications that you take regularly or have taken recently, include all non-prescription drugs.)

1.____________________ 3.,____________________

2.____________________ 4.____________________

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If **YES,** list which ones)____________________

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT			
PREVIOUS			

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.					
2.					
3.					
4.					
5.					
6.					

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family members, the cause of death and their ages at death.)____________________

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

/

SOCIAL HISTORY:

Do you smoke cigarettes? Yes / No How many/day?__________ How many years?__________

Do you drink alcohol? Yes / No How many drinks/day?__________ Per week?__________

Do you get any regular exercise? Yes / No How often?__________

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY

First day of last period:__________ Age first started period: ____ Usual number of days from one period to the next:__________

Usual # of days of flow: ________ Are your periods: Light / Moderate / Heavy Any excessive bleeding or spotting between cycles? Yes / No

Cramps with periods? Yes / No Depression, anxiety, emotional upset before periods? Yes / No

PAP SMEARS:

Last pelvic exam: __________ Last pap smear: __________ Have you ever had an abnormal pap? O Yes No D

If yes, what treatment was done?

Have your paps been normal since treatment? D Yes No D Did your mother take hormones while pregnant with you? O Yes No D

SEXUAL HISTORY:

Any history of STDs? HPV Yes / No Herpes Yes / No Syphilis Yes / No Hepatitis Yes / No HIV Yes / No

Gonorrhea Yes / No Chlamydia Yes / No Other?__________

List any Gynecologic surgeries, dates and reasons for surgery: