

GYN PATIENT FORM

PATIENT INFORMATION

Today's Date (mm/dd/yyyy) _____

PERSONAL INFORMATION

First Name: _____ Last Name: _____ MI: _____

Permanent Address: _____

City: _____ State/Province: _____ Zip Code: _____

Country (if outside US): _____

Phone 1: _____ Phone 2: _____

Local Address (if Different from permanent): _____

City: _____ State/Province: _____ Zip Code: _____

Social Security Number: _____ Sex : Male ___ Female ___

Date of Birth: _____

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

Employer: _____ Phone: _____

E-mail: _____

Pharmacy: 1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Insurance Information (Please provide all current insurance cards at registration).

Primary Insurance Company: _____

Is this: Medicare ___ MedicareHMO ___

Group Number: _____ ID Number: _____

Secondary Insurance Company: _____

Is this: Medicare ___ MedicareHMO ___

Referral Information: (Please provide referral at registration)

Referred by: Insurance website ___ Insurance book ___ Referring physician ___

Newspaper/magazine ad ___ Friend/relative ___ Name of person referring you: _____

Referring physician: _____ Phone: _____

Primary care Physician(if different): _____ Phone: _____

Patient's Name: _____ **DOB:** _____

GYNECOLOGIC HISTORY

How old were you when you first started your period?	
How many days in between periods?	
How long does your period last?	
How many pads or tampons do you change in a day when you have a period?	
Date of last period?	
Have you ever had any of the following sexually transmitted diseases? If yes , please circle: HIV HEPATITIS B HEPATITIS C GONORRHEA CHLAMYDIA HERPES VENEREAL WARTS TRICHOMONAS HPV (HUMAN PAPILOMA VIRUS)	
Have you ever had surgery on your cervix? Please list.	
Have you ever had surgery on your uterus, tubes or ovaries? Please list.	
Have you ever had any other gynecologic surgery? Please list.	
Have you ever had an ectopic (tubal) pregnancy?	
What was your most recent birth control method?	
How many total pregnancies have you had?	
How many children do you have?	
How many miscarriages have you had?	
How many abortions have you had?	

Patient's Name: _____

DOB: _____

PATIENT MEDICAL HISTORY

CONDITION	YES	NO	SPECIFY (If applicable)
Chest pain			
Shortness of breath			
Hypertension (high blood pressure)			
Hyperlipidemia (high cholesterol)			
Myocardial Infarction (heart attack)			
Congestive Heart Failure			
Abnormal Heart Beat			
Lightheadedness/Passing Out			
Enlarged Heart			
Heart Murmur			
Rheumatic Fever			
Stroke			
Blood Clots			
Peripheral Vascular Disease			
Swelling or Aching in Legs.			
CONDITION:	YES	NO	SPECIFY (If applicable)
Other Vascular			
Excessive Fatigue			
Diabetes			
Gastrointestinal Problems			
Orthopedic Problems			
Asthma.			
Emphysema			
Other Respiratory problems			
Headaches			
OB/GYN Problems			
Thyroid			
Urinary/Genitourinary			
Hematological			
Immunological			
Psychological/Psychiatric			
Neurologic Problems			
Other			

Patient's Name: _____ **DOB:** _____

EMERGENCY CONTACT INFORMATION

Spouses/Significant Other Contact Information:

Spouse Name: _____

Spouses Address (if different) _____

City: _____ State/Province _____ Zip Code _____

Country (if outside US): _____ Home phone _____

Cell phone: _____ Pager _____

Spouse Occupation: _____

Spouse Employer: _____ Work Phone _____

Other Relative Emergency contact:

Name of nearest Relative: _____ Relationship _____

Home Phone: _____ Work Phone _____

Cell Phone: _____ Pager: _____

IN CASE OF EMERGENCY, I HEREBY AUTHORIZE YOU TO CONTACT THE FOLLOWING EMERGENCY CONTACT (S):

Spouse/Significant Other _____ **Other nearest relative:** _____

PLEASE BE AWARE IN CASE OF EMERGENCY I HAVE COMPLETED THE FOLLOWING DOCUMENTS THAT I WILL PROVIDE TO THIS PHYSICIANS OFFICE WITHIN 10 DAYS OF SIGNATURE BELOW. I AM AWARE THAT MY REQUESTS CAN NOT BE FOLLOWED UNLESS APPROPRIATELY SIGNED LEGAL DOCUMENTS ARE MAINTAINED IN THIS CHART OR PROVIDED AT THE TIME OF EMERGENCY.

Living Will _____ **DNR/Do Not Resuscitate** _____

Patient signature

Witness Signature

Patient Name

Witness Name

Date: _____

