ANNUAL

Medical History UPDATE Form

Name: ____________________ Today'sDate: ____________________
Birthdate: ____________________ Age: ____________________
Primary Care Physician: ____________________ Preferred Lab: ____________________
Preferred Pharmacy: ____________________

Reason for Visit: Please check
❑ Annual - Well Woman Exam Check Up
❑ Problem - Please List: ____________________
1st Day of Most Recent Period: __________ Number of Pregnancies: __________ Number of Births: __________

Current Contraception: (Please indicate)
❑abstinence ❑withdrawal ❑rhythm ❑condoms ❑foam/spermicides ❑pills
❑patch ❑ring ❑Depo-Provera ❑implant ❑tubes tied/plugged ❑IUD
❑vasectomy ❑hysterectomy ❑infertility ❑menopause ❑same gender sexual partner ❑none

Health Maintenance and Modifiers: Please list dates of last test or treatment
Pap Smear: ____________________ Colonoscopy: ____________________
Mammogram: ____________________ Cholesterol/Lipid Screen: ____________________
Bone Density: ____________________ Gardasil/HPV vaccine: ____________________

Exercise: ❑none ❑irregular ❑regular ❑aerobic ❑weight bearing
Calcium: ❑none ❑ milk/dairy ❑dietary ❑supplements

Sexual Activity:
Are you currently in a sexual relationship? ❑Yes ❑No
New sexual partner in last year? ❑Yes ❑No
Current sexual partner ❑Male ❑Female
Prevention of Sexually Transmitted Infection: ❑Abstinence ❑Condoms ❑ Monogamy
Do you want testing for STIs: ❑Yes ❑No

Medical and Surgical History: Please list any changes since your last visit (heart disease, diabetes, surgeries, etc)

Date	Type of Surgery / New Medical Condition

Changes in Family Medical History since last visits: List Family Member (parent, grandparent, sibling, aunt, uncle, children) - Blood clotting disorders, cancers, heart disease, etc ____________________

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Allergies: (to medications, latex, iodine, shellfish, or nuts)

Allergy	Reaction Type

OBG-ANN-001 (03/19)

Current Medications or Supplements: (Name, dose and prescribing doctor)

Medication Name	Dosage	Frequency	Prescribing Doctor

Supplements: Supplements, Vitamins, etc

Supplement	Reason for use

Social:

Your Occupation: ______________________________

Your Employer: ______________________________

Marital Status: single engaged domestic partner married separated divorced widowed

Name of spouse/partner: ______________________________

Alcohol: Average number of drinks__________/day or__________/week or none

Tobacco: Do you smoke?: ❑Yes ❑No ❑Past
If yes, how many cigarettes per day?__________for how long? ______________________

Recreational Drug Use: ❑Yes ❑No ❑Past

Review of Systems: Please indicate any recent problems

General: ❑excessive fatigue ❑unexplained weight change ❑night sweats ❑hot flashes ❑heat or cold intolerance
Breasts: ❑change in skin ❑lumps ❑breast pain ❑discharge
Cardiovascular: ❑chest pain ❑palpitations
Respiratory: ❑unexplained cough ❑shortness of breath ❑wheezing
Gastrointestinal: ❑abdominal pain ❑bloating ❑nausea ❑vomiting ❑constipation ❑diarrhea ❑blood in stool ❑hemorrhoids
Genital/Urinary: ❑vaginal discharge ❑vaginal odor ❑problems with sex ❑leaking of urine ❑pain with urination ❑blood in urine ❑urgency
Skin: ❑new or changing skin lesions
Neurologic: ❑intense headaches
Cognitive/Emotional: ❑depression ❑anxiety ❑poor sleep
Heme-Lymph: ❑easy bruising or bleeding ❑ blood clots in leg or lung

OBG-ANN-002 (03/19)

Patient Signature / Date: ______________________________

Today's Date ______________________ **Please fill out ALL sections completely and legibly.**

DEMOGRAPHIC INFORMATION - Section A

Patient Name ______________________ Patient's Birth Date Month | Day | Year

Patient's Social Security Number ______________________ Referring Physician ______________________

Mailing Address ______________________ City __________ State ______ Zip ______

Home Phone ______________________ Cell Phone ______________________ Work Phone ______________________

What is your preferred contact number: Home | Cell | Work (please circle one)

Email ______________________

Spouse Name ______________________ Spouse's Birth Date Month | Day | Year

Spouse Email ______________________ Spouse's Preferred Phone Number ______________________

POLICY INFORMATION - Section B

Policy Holder's Name ______________________ Policy/ID Number ______________________

PLEASE COMPLETE SECTION C ONLY IF POLICY HOLDER IS NOT YOURSELF

POLICY HOLDER INFORMATION - Section C

Policy Holder's Birth Date Month | Day | Year Policy Holder's Social Security Number ______________________

Mailing Address ______________________ City __________ State ______ Zip ______

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize OB-GYN Associates to furnish information to insurance carriers concerning my illness(s) and treatment(s) and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amounts not covered, any share of costs under a policy or any amount not paid by insurance.

Patient Signature ______________________ Date Month | Day | Year

Guardian Signature if Patient is a Minor ______________________ Date Month | Day | Year

OB/Gyn Associates
Patient Authorization Form

Patient Name____
(please print)

It is the policy of OB/Gyn Associates to make confirmation phone calls to patients two days before their appointment. Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items. Please see below and mark accordingly.

I authorize the Staff of OB/Gyn Associates to leave a message on my **answering machine / personal voicemail** regarding*:

My Appointment	❏ No ❏ Yes
My Medical Care/Results	❏ No ❏ Yes
My Patient Account/Billing	❏ No ❏ Yes

We will not be able to leave a message if your voicemail doesn't include your name.

Also. If I am not available, I authorize the Staff of OB/Gyn Associates to **speak with** and release information to the following individual(s) regarding*:

Name	Relationship	Phone	Appointment	Medical/Results	Account/Billing
______________________	________________	_________	❏ No ❏ Yes	❏ No ❏ Yes	❏ No ❏ Yes
______________________	________________	_________	❏ No ❏ Yes	❏ No ❏ Yes	❏ No ❏ Yes
______________________	________________	_________	❏ No ❏ Yes	❏ No ❏ Yes	❏ No ❏ Yes

I authorize the Staff of OB/Gyn Associates to call my **work number**, if I am otherwise not available.
❏No ❏Yes

I authorize the Staff of OB/Gyn Associates to **leave a message on my voice mail** at my work number.
❏No ❏Yes

I understand that it is the policy of OB/Gyn Associates to take a **photo** of each patient for their Medical Chart.

I understand this release will remain valid and in place until revoked by me in writing.

______________________________________ ________________
Patient or Guardian Signature Date