ANNUAL

OB/GYN associates

Medical History UPDATE Form

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____

Primary Care Physician: _____ Preferred Lab: _____

Preferred Pharmacy: _____ Preferred Imaging Center: _____

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	

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

Date	Type of Surgery / New Medical Condition

NEW Family Medical Conditions: List Family Member (parent, grandparent, sibling, aunt, uncle, children)

Blood clotting disorders, cancers, heart disease, etc _____

_____

_____

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

Allergy	Reaction Type

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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

Patient Signature / Date: _____

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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