SPARTANBURG & PELHAM OB-GYN, P.A.

Patient Information **Account #** ________________

Name ______________________ Address ______________________

City ______________________ State ________ Zip Code ____________

Home Phone ______________________ Cell Phone ______________________

e-mail ______________________ Race______________________

I would prefer commuications from the office to be: ___Phone ___Cell ___Home ___email ___Letter

Primary Language ______________________ Marital Status ____________

Social Security# ______________________ Date of Birth ____________

Family Physician ______________________ Ref by ______________________

Preferred Pharmacy ____

Employer ______________________ Work Phone ______________________

Address ____

Religion ______________________ Emergency Contact# ______________________

Emergency Contact Name / Relationship ______________________

Are you against a blood transfusion in an emergency situation? ____________

If yes, why? ____

Spouse's Name ______________________ Date of Birth ____________

Spouse's employer ______________________ Phone ____________

Spouse's social security# ______________________

If you are 18 or a student, give parent information

Father's Name ______________________ Date of Birth ____________
Employer ______________________ Social Security# ____________

Mother's Name ______________________ Date of Birth ____________
Employer ______________________ Social Security# ____________

Can we contact your parents regarding insurance information? ____________
Are you covered under your parent's Insurance? ____________
List all insurance companies that you are currently covered under

Health Insurance Co	Policy #	Name of Insured	Date of Birth

Authorization to release information and assignment of benefits:

I hereby authorize Spartanburg & Pelham OB-GYN to furnish information to my insurance carriers concerning my condition and/or treatment, and hereby assign to the physician's) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Date Signature of Patient Parent's signature (if minor)

Name: ______ Date of Birth: ______ Date: ______

Reason for visit: ______ LMP: ______

Medical History Have you ever had any of the following?

__ Abnormal Pap	__ Blood Transfusion	__ Fibroids	__ Liver Disease/Hepatitis
__ Anemia	__ Cancer	__ Fibromyalgia	__ Migraines
__ Anxiety	__ Depression	__ Genetic Condition	__ Pneumonia
__ Arthritis	__ Diabetes	__ Heart Disease/Attack	__ Sickle Cell Disease
__ Asthma	__ Drug/Alcohol Problem	__ High Blood Pressure	__ Stroke
__ Bladder Infections	__ Endometriosis	__ High Cholesterol	__ Thyroid Problems
__ Blood Clots in Lung/Legs	__ Epilepsy/Seizures	__ Kidney Infections	__ Other ______

Have you ever had any of the following STD's? ____ Chlamydia __ HPV __ HIV __ None
____ Gonorrhea __ Syphilis __ Hepatitis B
____ Herpes __ Trichomonas __ Hepatitis C

Date of last Pap smear ____________________ ____ Normal __ Abnormal

Have you needed any of the following for an abnormal pap? __ Colposcopy __ None
____ Cryosurgery __ Leep/Laser/ Conization

Date of last Mammogram____________________ ____ Normal __ Abnormal __ Never

Date of last Bone Density____________________ ____ Normal __Osteopenia __Osteoporosis __Never had one

Date of last Colonoscopy____________________ ____ Never had one

Date of last Cholesterol test__________________ ____ Never had one Date of last Thyroid Test________

Surgical History Please list all surgeries with dates:

______ ______

______ ______

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

______ ______ ______ ______

______ ______ ______ ______

List any allergies to medications: ______ __ No Known Allergies

Family History Use these Abbreviations: **M**/Mother **F**/Father **MGM**/Maternal Grandmother **PGM**/Paternal Grandmother **MGF**/Maternal Grandfather **PGF**/Paternal Grandfather **A**/Aunt **U**/Uncle **S**/Sister **B**/Brother

	Relative / Age at Diagnosis
__ Breast cancer	
__ Ovarian cancer	
__ Uterine cancer	
__ Colon cancer	

	Relative
__ High Blood Pressure	
__ Diabetes	
__ Heart Disease (heart attack, stroke, bypass surgery)	

Obstetrical History

Total number of Pregnancies ______

Please list all pregnancies in order, including miscarriages, premature birth, stillbirths, ectopic (tubal), and abortions:

MM/DD/ YYYY	M/F	Type of Delivery	Length of Pregnancy	Length of Labor	Birth Weight	Hospital

GYN History Periods are: ____ Regular Flow is: __ Light

Age of first period ______ ____ Irregular __ Light to moderate

Date of last period ______ ____ Painful __ Moderate to Heavy

Cycle length: every ______ days ____ Not bothersome __ Very Heavy

How long do they last ______ days

Are you sexually active? __ Yes __ No

Sexual preference __ Male __ Female __ Both

New Partners? __ Yes __ No

Number of lifetime partners: ________________

Method of Birth Control: __ Condoms __ Pills __ Patch __ Depo Provera ____ Implanon ____ Vaginal ring ____ Tubal Ligation IUD __ Partner with Vasectomy __ Natural Family Planning __ Other ______________________ __ None

Social History

Alcohol use __ Yes __ No If yes,_______drink(s) per day/week/month

Tobacco use __ Yes __ No If yes,_______pack(s) per day for ____years

Street drug use __ Yes __ No Type and frequency________________________

Caffeine __ Yes __ No If yes,_______caffeinated drinks per day

Sexual Abuse __ Yes __ No If yes, are you safe now? __ Yes __ No
Counseling? __ Yes __ No

Physical Abuse __ Yes __ No If yes, are you safe now? __ Yes __ No
Counseling? __ Yes __ No

Emotional Abuse __ Yes __ No If yes, are you safe now? __ Yes __ No
Counseling? __ Yes __ No

Exercise __ Sedentary __ Minimal amount __ Moderate amount
__ Heavy amount __ Active, but no formal exercise

Have you had exposure to hazardous materials: ____ Yes __ No

Do you wear a seat belt? __ Yes __ No

Are you employed? __ Yes __ No If yes, describe type of job duties ______________________

__ Trade __ Skilled __ Professional

Education __ Current student __ Did not complete or attend __ GED

__ College, __2 year __4 year __ Graduate studies __ Post Grad studies __ Unknown

Military Status Have you ever served?___ Active:___ Retired: ___

Review of Systems Do you currently have any of the following?

General Health: __ Fatigue __ Fever __ Chills __ Body Aches __ Night Sweats __ Weight Gain __ Weight Loss

Eyes: __ Impaired Vision

HENT: __ Headaches __ Vertigo __ Lightheadedness

Breasts: __ Lumps __Tenderness __ Swelling __ Nipple Discharge __ Abnormal Changes in Breasts

Cardiovascular: __ Chest pain __ Dizziness __Irregular Heartbeat

Respiratory: __ Shortness of Breath __ Wheezing __ Cough

Gastrointestinal: __ Nausea __ Vomiting __ Diarrhea __ Constipation __ Blood in Stools __ Hemorrhoids

Neurologic: __ Muscular Weakness __ Incoordination __ Tingling or Numbness

Musculoskeletal: __ Joint Pain __ Muscle Pain

Psychiatric: __ Anxiety __Depression __ Feeling Confused __Difficulty Sleeping

Urinary: __ Urgency __Frequency __ Pain with Urination __ Leaking __Irregular Menses
__ Heavy Periods __Vaginal Discharge