

Medical History

Account # _____

Name _____ Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

e-mail _____ Marital Status _____

Social Security# _____ Date of Birth _____

Family Physician _____ Ref by _____

Employer _____ Work Phone _____

Address _____

Religion _____ Emergency Contact# _____

Emergency Contact Name / Relationship _____

Drug Allergies _____

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)

Check if you have had any of the following illnesses

	Yes	No	Don't Know
AIDS / HIV			
Allergies Drugs / Latex / Seasonal (circle all that apply)			
Amputations (any)			
Anemia			
Arteriosclerosis			
Arthritis			
Asthma			
Back Problems			
Blood Clots in legs or lungs			
Brain Damage			
Bronchitis			
Cerebral Palsy			
Cerebral Vascular Accident (stroke)			
Chicken Pox			
Colitis			
Deafness			
Diabetes			
Emphysema			
Epilepsy			
Fainting or Dizzy Spells			
German Measles			
Headaches (frequently?)			
Heart Problems			
Hemophilia			
Hepatitis			
Hernia			
Hypertension			
Hodgkin's Disease			
Jaundice			
Kidney Conditions			
Loss of Sight			
Measles			
Mental Retardation			
Multiple Sclerosis			
Mumps			
Muscular Dystrophy			
Osteomyelitis			
Parkinson's Disease			
Peptic Ulcer			
Poliomyelitis			
Psychological Problems			
Rheumatic Fever			
Ruptured Disc (back or neck)			
Shortness of Breath			
Thyroid Problems			

Check if you have had any of the following illnesses (continued)

	Yes	No	Don't Know
Swelling of Legs and Ankles			
Thrombophlebitis			
Tuberculosis			
Varicose Veins			
Other - Explain			
Other - Explain			

Family History (Do not indicate your husband's history)

	Cause of Death				If living how is health?
	Age	Living	Deceased	Death	
Father					
Mother					
Brothers					
Sisters					

Place an X by any of the following illnesses which have affected any near relative, and label as follows:

M=Mother, **F**=Father, **MGM**=Maternal Grandmother, **PGF**=Paternal Grandfather, **A**=Aunt, ect.

Tuberculosis	_____	Heart Attacks	_____
Epilepsy	_____	Kidney Disease	_____
Cancer	_____	Other	_____
Diabetes	_____		_____
High Blood Pressure	_____		_____

How old were you when you first started to menstruate? _____

Are your periods regular? _____ Yes No Circle one

How far apart are they? _____ days

How many days do they last? _____

Is the flow excessive, normal or scanty? _____

Do you have any discomfort with your periods? _____ Yes No

What was the date your last period began? _____

Do you ever bleed or spot between periods? _____

Do you have hot flashes or other symptoms of menopause? Yes No

Have you ever taken female hormones? Yes No

Have you had any vaginal bleeding since menopause? Yes No

Do you ever have a vaginal discharge? Yes No Frequently? Yes No

Date of your last Pap Smear _____ Results _____

What type of contraceptive do you use? _____

Have you ever been diagnosed with a sexually transmitted disease? Yes No

If so, please list _____