Print Form

Premier
OB/GYN of West Houston, L.L.P.

Patient Name _____Drivers Lic #_____
Last First Middle

Address _____City/State/Zip _____

Telephone: Home (_____)_____Work (_____)_____ Cell (_____)_____

Check One: _____Employed _____F/T Student _____P/T Student _____Unemployed

Check One: _____Single _____Married _____Other

Patient	**Spouse / *Parent**
Employer/School_____	Name_____
Emp/Sch Address_____	Wk Number_____
SS# _____	SS#_____
Date of Birth_____	Date of Birth_____

*If the patient is a dependent child, please complete the information in the Spouse section for the parent.

Next of Kin and Phone Number: _____

Relative or Friend not living at same address:

Name _____Relationship_____

Address_____Phone Number_____

Insurance Information

Primary Insurance	*Secondary Insurance*
Ins Co _____	Ins Co _____
Claims Address _____	Claims Address _____
City/State/Zip _____	City/State/Zip _____
Group Number _____	Group Number_____
Policy/ID# _____	Policy/ID#_____

Assignment of Insurance Benefits and Authorization to Release Information

I authorize payment of medical benefits to Premier OB/GYN of West Houston for any and all services not paid in full at the time those services are rendered.

I authorize Premier OB/GYN of West Houston to release any medical information as necessary for the completion of my insurance claims to any insurance carrier, health or hospital plan.

Premier Ob/Gyn of West Houston does not accept any form of Medicaid.

Patient _____ Date _____

Patient's Legal Guardian/Agent_____ Date _____

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Date_____Name_____Age_____

Reason for today's visit _____

_____

What changes have there been in your life recently? _____

_____

Date of last Pap Smear_____ Results _____

Date of last Mammogram _____ Results _____

Date of last Bone Density _____ Results _____

Date of last menstrual period _____ Are your periods regular? _____

Any problems with periods? _____

Are you sexually active? _____ If yes, any difficulties or discomfort? _____

Do you want to change birth control?_____ If yes, to what? _____

Are you trying to get pregnant?_____If not, preventative method (vasectomy, tubal ligation, condoms, birth control pills, etc…)_____

With respect to your female organs, have you ever had: (Circle all that apply)

Abnormal bleeding ☐ Infections of the Tubes or Ovaries ☐ Tubal (Ectopic) Pregnancy ☐

Chlamydia/Gonorrhea/Syphilis ☐ Tumor of the Uterus or Ovaries ☐ Herpes Infection ☐

Have you ever had an abnormal Pap Smear? _____ Treatment? _____

Number of: ___Pregnancies___Deliveries ___Miscarriages ___Abortions___Living children

Please list previous pregnancies in chronological order:

MM/DD/YR	Sex	Wt	Hrs in Labor	Anesthesia	Complications
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____

Genetic: Have you or your husband been tested for the following? (Circle all that apply)

Sickle Cell ☐ Thalassemia ☐ Tay-Sachs ☐ BRACA ☐ Cystic Fibrosis ☐

Other genetic disorder/carrier? _____

Current medication & dose _____

_____

List all allergies to medications: _____

Pharmacy Name & Phone # _____

Do you need 1 month or 90 day prescription? _____

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Date_____Name_____Age_____

Past History: (Circle all that apply)

Arthritis	Hepatitis	Migraine Headaches	Rheumatic Fever
Asthma	High Blood Pressure Mitral	Valve Prolapse	Thrombophlebitis
Breast Problems	High Cholesterol	Neurological Disease	Thyroid Problems
Diabetes	Intestinal Bleeding	Osteoporosis	
Heart Attack	Kidney Infection	Paralysis	
Heart Murmur	Kidney Stone	Pneumonia	

Other Diseases or Conditions: _____

_____

Infectious Diseases (TB. HIV, Hepatitis)_____

Will you permit a blood transfusion for medical reasons? _____

List all surgeries:

Type of surgery	Approximate Date	Type of surgery	Approximate Date
1._____		3._____	
2._____		4._____	

Social History: Race_____ Occupation_____

Do you drink alcohol? _____ If yes, estimated number of drinks per week _____

Do you smoke? _____ How many packs a day? _____

Are you using any other drugs? _____ If yes, what type? _____

Family History: Is there a member of your family with a history of:

_____Cancer—what type _____	Who? _____
_____Congenital (Inherited) Disease	Who? _____
_____Diabetes/Thyroid Disease	Who? _____
_____Heart Disease	Who? _____
_____High Blood Pressure	Who? _____
_____High Cholesterol	Who? _____
_____Kidney Disease	Who? _____
_____Lupus/Rheumatoid	Who? _____
_____Osteoporosis	Who? _____
_____Twins	Who? _____
_____Mental Retardation/Autism	Who? _____
_____Neurologic	Who? _____