

Patient Name _____ Drivers Lic # _____
Last First Middle

Address: _____ City, St, Zip _____

Telephone: Home (_____) _____ Work (_____) _____

Check One: Employed _____ F/T Student _____ P/T Student _____ Unemployed _____

Check One: Single _____ Married _____ Other _____

Patient

Employer/School _____

Emp/Sch Address _____

SS# _____

Date of Birth _____

Spouse/*Parent

Name _____

Work Number _____

SS# _____

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

Ins Co _____

Claims Address _____

City, St, Zip _____

Group Number _____

Policy/ID # _____

Secondary Insurance

Ins Co _____

Claims Address _____

City, State, Zip _____

Group Number _____

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.

Patient _____ Date _____

Patient's Legal Guardian/Agent _____ Date _____

Date _____ Name _____ Age _____

Past History: Circle all that apply

- | | | | |
|-----------------------------|---------------------|-------------------------------------------|------------------|
| Arthritis | Hepatitis | Migraine Headaches | Rheumatic Fever |
| Asthma | High Blood Pressure | Mitral Valve Prolapse | Thrombophlebitis |
| Breast Tumor | High Cholesterol | Neurological Disease | Thyroid Problems |
| Diabetes | Intestinal Bleeding | Osteoporosis | |
| Heart Attack | Kidney Infection | Paralysis | |
| Heart Murmur | Kidney Stone | Pneumonia | |
| Other Heart Disease: _____ | | Infectious Disease (TB,HIV,etc...): _____ | |
| Other Kidney Disease: _____ | | Other Lung Disease: _____ | |
| Other: _____ | | | |

List all other surgeries:

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

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

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Will you permit a blood transfusion for medical reasons? _____

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

Any problems with periods? _____ Present type of birth control _____

Do you want to change birth control? _____ To what? _____

Did your mother take DES or other hormones while pregnant with you? _____

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

- | | | |
|------------------------------|------------------------------------|--------------------------------|
| Abnormal bleeding | Herpes Infection | Tubal (Ectopic) Pregnancy |
| Chlamydia/Gonorrhea/Syphilis | Infections of the Tubes or Ovaries | Tumor of the Uterus or Ovaries |
| Genital warts | | |

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

List all currently used medications: _____

List all allergies to medications: _____

Date _____ Name _____ Age _____

Genetic: If you or your husband are in the following categories, please respond: Answer Yes or No

If of African American or Indian descent, have you or your husband had Sickle Cell carrier testing? _____

If of Italian or Greek descent, have you or your husband had Thalassemia carrier testing? _____

If of Jewish descent, have you or your husband had Tay-Sachs carrier testing? _____

Additional explanation of past history: _____

Race: _____ Occupation: _____

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

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

Are you using any other drugs? _____ Type: _____

Are you sexually active? _____ Any difficulties or discomfort? _____

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

_____ Cancer – Type: _____ Who? _____

_____ Congenital (Inherited) Disease Who? _____

_____ Diabetes Who? _____

_____ Heart Disease Who? _____

_____ High Blood Pressure Who? _____

_____ High Cholesterol Who? _____

_____ Kidney Disease Who? _____

_____ Mental Retardation Who? _____

_____ Osteoporosis Who? _____

_____ Twins Who? _____

Date of last Pap Smear _____ Results _____

Date of last Mammogram _____ Results _____

Date of last Bone Density _____ Results _____

Reason for today's visit: _____

What changes have there been in your life recently? _____

Pharmacy Name & Phone # _____

Do you need 1 month or 90 day prescriptions? _____