

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

Employer/School _____

Emp/Sch Address _____

SS# _____

Date of Birth _____

Spouse/*Parent

Name _____

Wk 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/State/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.

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

Patient _____ Date _____

Patient's Legal Guardian/Agent _____ Date _____

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? _____

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? _____ |