

ANNUAL



Medical History UPDATE Form

Name: Birthdate: Primary Care Physician: Preferred Pharmacy:

Today's Date: Age: Preferred Lab:

Reason for Visit: Please check

- Annual - Well Woman Exam Check Up
Problem - Please List:

1st Day of Most Recent Period: Number of Pregnancies: Number of Births:

- Current Contraception: abstinence, withdrawal, rhythm, condoms, foam/spermicides, pills, patch, ring, Depo-Provera, implant, tubes tied/plugged, IUD, vasectomy, hysterectomy, infertility, menopause, same gender sexual partner, none

Health Maintenance and Modifiers: Please list dates of last test or treatment

Pap Smear: Colonoscopy: Mammogram: Cholesterol/Lipid Screen: Bone Density: Gardasil/HPV vaccine:

Exercise: none, irregular, regular, aerobic, weight bearing
Calcium: none, milk/dairy, dietary, supplements

Sexual Activity:

- Are you currently in a sexual relationship? Yes/No
New sexual partner in last year? Yes/No
Current sexual partner Male/Female
Prevention of Sexually Transmitted Infection: Abstinence/Condoms/Monogamy
Do you want testing for STIs? Yes/No

Medical and Surgical History: Please any changes since your last visit(heart disease, diabetes, surgeries, etc)

Table with 2 columns: Date, Type of Surgery / New Medical Condition

Changes in Family Medical History since last visits: List Family Member (parent, grandparent, sibling, aunt, uncle, children) - Blood clotting disorders, cancers, heart disease, etc

Allergies: (to medications, latex, iodine, shellfish, or nuts)

Table with 2 columns: Allergy, Reaction Type



Current Medications or Supplements: (Name, dose and prescribing doctor)

Medication Name	Dosage	Frequency	Prescribing Doctor

Supplements: Supplements, Vitamins, etc

Supplement	Reason for use

Social:

Marital Status: single engaged domestic partner married separated divorced widowed

Alcohol: Average number of drinks _____/day or _____/week or none

Tobacco: Do you smoke?: Yes No Past
 If yes, how many cigarettes per day? _____ for how long? _____

Recreational Drug Use: Yes No Past

Review of Systems: Please indicate any recent problems

- General:** excessive fatigue unexplained weight change
- night sweats hot flashes heat or cold intolerance
- Breasts:** change in skin lumps breast pain discharge
- Cardiovascular:** chest pain palpitations
- Respiratory:** unexplained cough shortness of breath wheezing
- Gastrointestinal:** abdominal pain bloating nausea vomiting
- constipation diarrhea blood in stool hemorrhoids
- Genital/Urinary:** vaginal discharge vaginal odor problems with sex
- leaking of urine pain with urination blood in urine urgency
- Skin:** new or changing skin lesions
- Neurologic:** intense headaches
- Cognitive/Emotional:** depression anxiety poor sleep
- Heme-Lymph:** easy bruising or bleeding blood clots in leg or lung

Patient Signature / Date: _____



Today's Date _____ Please fill out ALL sections completely and legibly.

DEMOGRAPHIC INFORMATION - Section A

Patient Name _____	Patient's Birth Date	Month	Day	Year
Patient's Social Security Number _____	Referring Physician	_____		
Mailing Address _____	City _____	State _____	Zip _____	
Home Phone _____	Cell Phone _____	Work Phone _____		
What is your preferred contact number: Home Cell Work (please circle one)				
Email _____				
Spouse Name _____	Spouse's Birth Date	Month	Day	Year
Spouse Email _____	Spouse's Preferred Phone Number	_____		

POLICY INFORMATION - Section B

Policy Holder's Name _____	Policy/ID Number _____
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PLEASE COMPLETE SECTION C ONLY IF POLICY HOLDER IS NOT YOURSELF

POLICY HOLDER INFORMATION - Section C

Policy Holder's Birth Date	Month	Day	Year	Policy Holder's Social Security Number _____
Mailing Address _____	City _____	State _____	Zip _____	

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize OB-GYN Associates to furnish information to insurance carriers concerning my illness(s) and treatment(s) and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amounts not covered, any share of costs under a policy or any amount not paid by insurance.

Patient Signature _____ Date Month | Day | Year

Guardian Signature if Patient is a Minor _____ Date Month | Day | Year

OB/Gyn Associates
Patient Authorization Form



Patient Name _____
(please print)

It is the policy of OB/Gyn Associates to make confirmation phone calls to patients two days before their appointment. Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items. Please see below and mark accordingly.

I authorize the Staff of OB/Gyn Associates to leave a message on my **answering machine** regarding:

My Appointment	<input type="checkbox"/> No	<input type="checkbox"/> Yes
My Medical Care/Results	<input type="checkbox"/> No	<input type="checkbox"/> Yes
My Patient Account/Billing	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Also, if I am not available, I authorize the Staff of OB/Gyn Associates to **speak with** and release information to the following individual(s) regarding:

Name	Relationship	Phone	Appointment	Medical/Results	Account/Billing
			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

I authorize the Staff of OB/Gyn Associates to call my **work number**, if I am otherwise not available.
No Yes

I authorize the Staff of OB/Gyn Associates to **leave a message on my voice mail** at my work number.
No Yes

I understand that it is the policy of OB/Gyn Associates to take a **photo** of each patient for their Medical Chart.
I understand this release will remain valid and in place until revoked by me in writing.

Patient or Guardian Signature

Date