COLON SCREEN? LIPIDS?

OB-GYN Associates of Shreveport – GYN Patient Information

PATIENT NAME:_____ **DATE:**____/____/____ **BIRTHDATE:**____/____/____

REFERRED BY:_____ **AGE:**_____

REASON FOR VISIT: ☐ **ROUTINE PHYSICAL** ☐ **PROBLEM** **DESCRIBE PROBLEM:** _____

Please fill out each page as completely as possible!

CHECK IF YOU HAD ANY OF THESE MEDICAL ILLNESSES IN THE PAST:

MAJOR ILLNESSES	YES	NO	**MAJOR ILLNESSES**	YES	NO
Anemia			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			Kidney Stones		
Chicken Pox			Osteoporosis		
Breast Cancer When? _____			Sexually Transmitted Diseases Type? _____		
Cancer - Other Type? _____			Thyroid Disease		
Diabetes			Urinary Tract/Kidney Infection/Stones		
Eating Disorder			Other:		
Heart Trouble Type? _____					

WHEN WAS YOUR LAST TEST?

TEST	DATE	**TEST**	DATE
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		OTHER:	
Last PAP Smear			
☐Normal ☐Abnormal			

PLEASE LIST ANY OPERATIONS OR PROCEDURES YOU HAVE HAD:

GYN SURGERY/PROCEDURE	DATE	**GYN SURGERY /PROCEDURE**	DATE
Colposcopy		Endometrial Biopsy	
Cryotherapy		LEEP	
D and C		OTHER GYN:	
Hysterectomy			
☐Vaginal ☐Abdominal		OTHER SURGERIES:	
Ovaries Removed Yes ☐ No ☐			

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	**WHAT BLOOD RELATIVE?**	**Maternal or Paternal?**
Breast Cancer				
Cancer Other Type? _____				
Diabetes				
Gynecological Problems				
Heart Trouble / Murmur				
High Blood Pressure				
High Cholesterol				
Sickle Cell Disease				
Thyroid Disease				
OTHER:				

YOUR GYN HISTORY

Do you use birth control? ☐ Yes ☐ No	
❑ Condoms	❑ Nuvaring
❑ Depo Provera	❑ Birth Control Patch
❑ Diaphragm	❑ None
❑ IUD- Kind	❑ Natural Family Plan/Rhythm
- Date Inserted:	❑ Tubal Ligation
❑ Birth Control Pill	❑ Vasectomy
– Name:	❑ Withdrawal
❑ Contraceptive Foam/Jelly	❑ Other:
What age did you have your first period: _____	
How many days are there from start of period to start of next period: _____ days	
How long does your period last?_____ days	Flow: (Check one) ☐ Light ☐ Medium ☐ Heavy
Number of Tampons per day: _____	Number of Pads per day: _____
Date of Last Period: _____	
Do you have clots? ☐ Yes ☐ No	Do you have breakthrough bleeding? ☐ Yes ☐ No
Have you gone thru Menopause: ☐ Yes ☐ No	At what age: _____
Are you on Hormone Replacement Therapy (hormones)? ☐ Yes ☐ No	

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature		Abortions Induced	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.
If you have had a tubal ligation, previous hysterectomy, or if you are postmenopausal you may skip to the next section.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex		Del Type Vag/CSection	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1					M F						
2					M F						
3					M F						
4					M F						
5					M F						
6					M F						

SOCIAL HISTORY

Do you Exercise: ☐ None ☐ Less than 3 times per week ☐ More than 3 times per week
Do you do a Self Breast Exam ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No
New sexual partner ☐ Yes ☐ No
Do you Take Calcium ☐ Yes ☐ No Name and Dosage:
Smoking ☐ Yes ☐ No Packs per day: _____ Number of Years: _____
Alcohol ☐ Yes ☐ No Drinks per day: _____ Drink per week: _____
Drug User ☐ Yes ☐ No Kind: Frequency:
Marital Status ☐ Single ☐ Married ☐ Widowed
Occupation: _____

MEDICATIONS (IMPORTANT!!!)

ALLERGIC TO ANY MEDICATIONS? Yes ____ No ____	List:
OTHER ALLERGIES? Yes ____ No ____ **List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking**	List:

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:					
DRUG NAME	**DOSAGE**	**PHYSICIAN**	**DRUG NAME**	**DOSAGE**	**PHYSICIAN**

CONSTITUTIONAL		**NOTES**
Weight Loss	❑	
Weight Gain	❑	
Hot Flashes	❑	
CARDIOLOGY		
Chest Pain	❑	
Shortness of Breath	❑	
BREAST		
Lumps	❑	
Tenderness	❑	
Swelling	❑	
Discharge	❑	
Pain in Breast	❑	
Abnormal Changes in Breast	❑	
GASTROINTESTINAL		
Nausea	❑	
Vomiting	❑	
Diarrhea	❑	
Jaundice	❑	
Abdominal Pain	❑	
PSYCHIATRIC		
Anxiety	❑	
Depression	❑	
ALLERGIC/ IMMUNOLOGIC		
Frequent illness	❑	
Seasonal Allergies	❑	

GENITOURNARY		**NOTES**
Urgency of urination	❑	
Frequency of urination	❑	
Pain with urination	❑	
Nighttime urination	❑	
Losing urine	❑	
Blood in urine	❑	
Decreased sex drive	❑	
Painful intercourse	❑	
Possible Pregnancy	❑	
Genital Sores	❑	
Pelvic Pain	❑	
Abnormal Vaginal Bleeding	❑	
Painful Periods	❑	
ENDOCRINE		
Loss of Hair	❑	
Difficulty Tolerating Cold	❑	
Difficulty Tolerating Heat	❑	
HEMATOLOGIC/ LYMPHATIC		
Bruises, frequent or easily	❑	
Cuts do not stop bleeding	❑	
Enlarged lymph nodes	❑	
OTHER		
_____	❑	
_____	❑	

OB/GYN Associates of Shreveport

INFORMATION REGARDING THE PATIENT

Last Name _____ First Name _____ MI _____

(Circle Marital Status)

Date of Birth _____ Age _____ SSN# _____ S M D W Sep

Street Address _____ City, State, Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Patient's Employer _____ Business Phone ( ) _____

Spouse Name _____ Cell Phone ( ) _____

Date of Birth _____ Age _____ SSN # _____

Employer _____ Business Phone ( ) _____

Father's Name _____ SSN# _____ Date of Birth _____

(if patient is a minor) Phone # ( ) _____

Employer _____ Business Phone ( ) _____

Mother's Name _____ SSN# _____ Date of Birth _____

(if patient is a minor) Phone # ( ) _____

Employer _____ Business Phone ( ) _____

Nearest relative not living with you _____

Relationship to you _____ Phone # ( ) _____

PERSON RESPONSIBLE FOR PAYMENT AFTER INSURANCE, IF NOT PATIENT

Name _____ Relation to the Patient _____

Billing Address (if different from above) _____

ANY INSURANCE REFERRALS/AUTHORIZATION NUMBERS ARE THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY BEFORE THE TIME OF SERVICE.

INSURANCE INFORMATION

(Please present insurance cards at check-in)

Primary Insurance Company _____

Whose Name is Insurance Under? _____ Relation to the Patient _____

SSN# _____ Date of Birth _____

Secondary Insurance Company _____

Whose Name is Insurance Under? _____ Relation to the Patient _____

SSN# _____ Date of Birth _____

I hereby authorize OB/GYN Associates of Shreveport to furnish information concerning my illness and treatments to insurance carriers, other physicians/health care personnel and my spouse. I hereby assign to the physician(s) all payments for medical service rendered to myself or my dependents. I also agree to pay all attorney and collection fees associated with the collection of fees for any services rendered. I understand that I am responsible for any amount incurred.

Signature _____ **Date** _____

OB/GYN Associates of Shreveport
Consent/Authorization

Patient Name _____ Date of Birth _____

Insurance Authorization/Payment Policy

Assignment/Release

I, the undersigned, certify that I (or my dependent) have insurance with the above named insurance company (ies), and assign directly to OB/GYN Associates of Shreveport all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that for medical/legal purposes, and medical records taken/created by this office are the property of OB/GYN Associates of Shreveport. I also understand that all charges for services are due and payable at the time the services are rendered. We accept cash, checks, Mastercard, Visa, Discover and American Express.

Payment Policies

All copays, deductibles, and coinsurance are due at the time of service. If you belong to an HMO, you will need a referral. If you belong to a PPO, you may have a deductible. Remember, it is your responsibility as a patient to get a referral if one is required. If you do not have one, you will be responsible for out-of-network benefits. Please let the receptionist know if you have new insurance at your time of arrival.
Notice to all patients paying by check: If you pay by check and it is returned for any reason from your bank you will automatically be assessed a $25.00 return check fee.

Medical Records Release and Forms

I understand that if I request a copy of my medical records to be sent to another doctor, I must allow 15 business days for processing from the time I submit a signed authorization. I understand that if I request my medical records to be released to me, I must pre-pay $25 for in-house records and $30 for records in storage and allow 15 business days for processing from the time I submit a signed authorization.
I understand if I submit a disability form, Family Medical Leave Act form, or any other form that requires a doctor signature and/or specific information to be completed, I will be charged $10 and must allow 15 business days for processing.

I, _____ hereby authorize OB/GYN Associates of Shreveport to release any information, in the course of my treatment, necessary to process insurance claims and/or to any other requesting physician in reference to referrals or coordination of care.

Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize OB/GYN Associates of Shreveport to release and discuss my medical/billing information and records to the following individuals. (This should include **friends or family members responsible for picking up your records when you are unable to do so.) PLEASE PRINT**

_____ Relationship: _____

_____ Relationship: _____

Patient Signature
By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent and agree with the information stated in each section.

_____	_____	_____
Patient/Legal Representative Signature	Legal Representative's Relationship To Patient	Date