Please fill out each page as completely as possible!

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

<table>
<thead>
<tr>
<th>MAJOR ILLNESSES</th>
<th>YES</th>
<th>NO</th>
<th>MAJOR ILLNESSES</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Kidney Stones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusions</td>
<td></td>
<td></td>
<td>Osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td>Sexually Transmitted Diseases Type?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer When?</td>
<td></td>
<td></td>
<td>Thyroid Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer - Other Type?</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Urinary Tract/Kidney Infection/Stones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder Type?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Trouble Type?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### WHEN WAS YOUR LAST TEST?

<table>
<thead>
<tr>
<th>TEST</th>
<th>DATE</th>
<th>TEST</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Density</td>
<td></td>
<td>Mammogram</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy / Sigmoidoscopy</td>
<td></td>
<td>OTHER:</td>
<td></td>
</tr>
<tr>
<td>Last PAP Smear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td>Abnormal</td>
<td></td>
</tr>
</tbody>
</table>

### PLEASE LIST ANY OPERATIONS OR PROCEDURES YOU HAVE HAD:

<table>
<thead>
<tr>
<th>GYN SURGERY/PROCEDURE</th>
<th>DATE</th>
<th>GYN SURGERY /PROCEDURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colposcopy</td>
<td></td>
<td>Endometrial Biopsy</td>
<td></td>
</tr>
<tr>
<td>Cryotherapy</td>
<td></td>
<td>LEEP</td>
<td></td>
</tr>
<tr>
<td>D and C</td>
<td></td>
<td>OTHER GYN:</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td></td>
<td>OTHER SURGERIES:</td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td></td>
<td>Abdominal</td>
<td></td>
</tr>
<tr>
<td>Ovaries Removed</td>
<td></td>
<td>Yes □ No □</td>
<td></td>
</tr>
</tbody>
</table>

### CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

<table>
<thead>
<tr>
<th>MAJOR ILLNESSES</th>
<th>YES</th>
<th>NO</th>
<th>WHAT BLOOD RELATIVE?</th>
<th>Maternal or Paternal?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Other Type?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecological Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Trouble / Murmur</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of pregnancies</td>
<td>Full term births</td>
</tr>
<tr>
<td>Premature</td>
<td>Abortions Induced</td>
</tr>
<tr>
<td>Miscarriages</td>
<td>Living children</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>N o.</th>
<th>Birth Date Wks Gest</th>
<th>Labor (hrs)</th>
<th>Baby’s Weight/Sex</th>
<th>Del Type Vag/CSection</th>
<th>Anes</th>
<th>Early Labor?</th>
<th>Wt Gain</th>
<th>Comments / Complications</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

**PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:**

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DOSAGE</th>
<th>PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CONSTITUTIONAL**

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  

**GENITOURINARY**

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)

Employer ____________________________ Business Phone ( )

Mother’s Name ____________________________ SSN# _______________ Date of Birth ________
(if patient is a minor)

Employer ____________________________ Business Phone ( )

Nearest relative not living with you ____________________________ Phone # ( )

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 ________________