Obstetrics & Gynecology

401 Lowell Drive Suite 1 • Huntsville, AL 35801
(256) 265-4462 • f: (256) 265-4463

PATIENT INFORMATION

PLEASE PRINT DATE____________________

Patient's Name ____ Referred By ______________
LAST FIRST MI

Address ______________________________ City ________________ State ______ Zip __________

Home Phone ____________________ Work Phone __________________ Cell Phone ________________

SS# _________-_______-_______ Sex M F D.O.B.______/__________/_______ Age______

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Email Address ____

Patient's Occupation ______________________________ Employer:__________________________

Employer's Address ______________________________ Employer's Phone (_____)________________

Spouse's Name __________________ Spouse's D.O.B. _____/_____/_____ Spouse's SS # _____-______-_____

Spouse's Occupation ________________________ Spouse's Employer____________________________

Employer's Address ______________________________ Employer's Phone (_____)________________

Notify in case of emergency ___________________________ Relationship ________________________

City ________________________________ State ____________ Phone (_____)________________

If patient is a minor, list person other than responsible party above who has permission to bring the child for treatment:

Name ___________________________ Relationship ______________ Phone ____________________

PERSON RESPONSIBLE FOR THIS ACCOUNT: ___________________ Phone ______________________

REQUEST TO RELEASE HEALTH INFORMATION ACCESS

I hereby release Huntsville Hospital Obstetrics and Gynecology to communicate to the following family members or friends:

Name ________________________ Relationship ______________ Phone ______________________

Name ________________________ Relationship ______________ Phone ______________________

Name ________________________ Relationship ______________ Phone ______________________

Name ________________________ Relationship ______________ Phone ______________________

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physicians Care to release information to insurance carriers and for insurance carriers to release information to HH Physicians Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Patient signature ____________________________ Date ________________________ Time___________

Signature of legal representative _________________________ Patient relationship ______________________

Witness signature ____________________________ Date ________________________ Time___________

GYN HISTORY/PROBLEMS

☐ **No Previous GYN Problems**

Please check if you have or have ever been diagnosed with any of the following problems:

☐ Abnormal Pap Smear
☐ Bartholin Cyst
☐ Bleeding Between Periods
☐ Breast Cancer
☐ Breast Lump
☐ Cervical Cancer
☐ Cervical Dysplasia
☐ Chronic Vaginal Infections
☐ Chronic Pelvic Pain
☐ Endometrial Hyperplasia
☐ Endometriosis

☐ Fibrocystic Breast
☐ Habitual Aborter (>3 Miscarriages)
☐ Heavy Periods
☐ Infertility
☐ Irregular Periods
☐ Lichen Sclerosis
☐ Ovarian Cancer
☐ Ovarian Cyst
☐ Pelvic Inflammatory Disease
☐ Prolapse
☐ Severe Cramps

☐ Sexually Transmitted Disease
  ☐ Chlamydia ☐ Genital Warts
  ☐ Gonorrhea ☐ HIV
  ☐ Herpes ☐ Trichomonas
☐ Urinary Incontinence
☐ Uterine Cancer
☐ Uterine Fibroids
☐ Vaginal Burning
☐ Vaginal Discharge
☐ Vaginal Itching
☐ Other ______________________________
____

GYN PERIOD HISTORY

Age at First Period____ Length of Period____
Frequency of Period______________________________________ Menstrual Flow ☐ Light ☐ Medium ☐ Heavy
HPV Vaccine ☐ YES ☐ NO Self-Breast Exams ☐ YES ☐ NO
IF Menopausal, Hormone Replacement Therapy ☐ YES ☐ NO

SURGICAL HISTORY

☐ **No Previous Surgeries**

Have you ever had any of the following surgeries, and if so when:

	Age	Year
☐ Arthroscopy (__________________)		
☐ Appendectomy/Appendix		
☐ Cataract		
☐ Cardiac Surgery (______________)		
☐ Cystoscopy		
☐ Gallbladder Removed		
☐ Hip Replacement R or L		
☐ Knee Replacement R or L		

	Age	Year
☐ Sinus Surgery		
☐ Tonsillectomy		
☐ Tonsillectomy/Adenoid		
☐ Tubes in Ears		
☐ Wisdom Tooth Extraction		
☐ Other: ________________________		
____________________________________		
____________________________________		

GYN SURGICAL HISTORY

☐ **No Previous Surgeries**

Have you ever had any of the following surgeries, and if so when:

	Age	Year
☐ Breast Augmentation		
☐ Breast Biopsy		
☐ Breast Reduction		
☐ Cesarean Section		
☐ Cervical Procedure		
☐ Cone Biopsy		
☐ Cryo		
☐ Laser		
☐ LEEP		
☐ Colposcopy		

	Age	Year
☐ D&C		
☐ Endometrial Biopsy		
☐ Tubal Ligation		
☐ Hysterectomy Abd / Vag		
☐ Laparoscopy		
☐ Laparotomy		
☐ Mastectomy R / L / B		
☐ Ovaries Removed R / L / B		
☐ Other: ________________________		
____________________________________		

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed ☐ Engaged ☐ Domestic Partner

Occupation: ______________________________ ☐ Unemployed ☐ Disabled

Place of Employment: ______________________________

Level of Education: ______________________________

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: ______________

Diet: ☐ Diabetic ☐ Healthy ☐ High Fat ☐ Low Fat ☐ Low Sodium ☐ Junk Food

Exercise: ☐ 2-3x/week ☐ 3-4x/week ☐ Daily ☐ Never ☐ Occasional Rarely

Tobacco Use: ☐ No ☐ Yes ☐ Former **Type:** __________ **Amt/day:** ________ **#Years:** _____ **Years Quit:**_____

Caffeine Use: ☐ No ☐ Yes ☐ Former **Type:** __________ **Amt/day:** ________

Alcohol Use: ☐ No ☐ Yes ☐ Former **Type:** __________ **Amt/day:** ________ **#Years:** _____ **Years Quit:**_____

Illicit Drug Use: ☐ No ☐ Yes ☐ Former **Type:** __________ **Amt/day:** ________ **#Years:** _____ **Years Quit:**_____

Stress Level: ☐ Low ☐ Moderate ☐ High

Sexual Preference: ☐ Men ☐ Women ☐ Both **Sexually Active:** ☐ YES ☐ NO **Protected Sex:** ☐ YES ☐ NO

History of Physical or Sexual Abuse? ☐ YES ☐ NO **Currently in an Abusive Relationship?** ☐ YES ☐ NO

Religious Preference: ______________________________

Accept Blood Transfusion: ☐ YES ☐ NO **Advanced Directive or Living Will:** ☐ YES ☐ NO

OBSTETRICIAL SOCIAL HISTORY

☐ **Not Pregnant**

Father of Baby: ______________________

Father of Baby's Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: ______________

Change in family/social situation: ☐ Yes ☐ No **Do you have cats?** ☐ No ☐ Indoor Only ☐ Indoor/Outdoor ☐ Outdoor

Passive Smoke Exposure: ☐ Yes ☐ No **Smoke/CO2 Detectors:** ☐ Yes ☐ No

Occupational Health Risks: ☐ Yes ☐ No **Frequent Air Travel:** ☐ Yes ☐ No

Have you recently (within the last 12 weeks, or during current pregnancy) traveled to or lived in a zika-affected area?
☐ No ☐ Yes: Do you have symptoms associated with zika virus (fever, rash, joint pain or conjunctivitis)? ☐ Yes ☐ No

OBSTETRICIAL HISTORY

☐ **No Previous Pregnancy**

Please fill out for each pregnancy even if it was a miscarriage or abortion. *If you've had a tubal ligation, hysterectomy, or are over the age of 60, only date and type of delivery are necessary.*

Preg. #	Type of Delivery	Date of Birth	Gestational Age	Birth Weight	Sex	Hospital	Doctor	Complications
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			
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	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			

FAMILY MEDICAL HISTORY

☐ Unknown ☐ Patient Adopted ☐ None

Please check if anyone in your immediate family has been diagnosed or treated for the following:

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoprosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problems with Anesthesia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: ____________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: ____________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HEALTH HISTORY QUESTIONNAIRE

Name_______________________________________ Birthdate_______________

Reason For Visit: ______________________________ Primary Care Provider:____________________

Pharmacy # 1: ____________________________ Location: ____________________ Phone #:__________

Pharmacy # 2: ____________________________ Location: ____________________ Phone #:__________

Medication allergies and reactions: ____

____

☐ No Home Medications ☐ No Known Medication Allergies

Please include all over the counter medication and prescription medications.

Medications	Dose/Strength	# of Pills/amt	Times/day

MEDICAL HISTORY

Please check if you have or have ever been diagnosed with any of the following conditions:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clot (PE, DVT)
- ☐ Blood Transfusion
- ☐ Bowel Problems
- ☐ Chronic Urinary Infection
- ☐ Diabetes (type___________)
- ☐ Elevated Cholesterol
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Problems
  - ☐ Angina ☐ Heart Disease
- ☐ Heartburn/Reflux
- ☐ Hepatitis (type________)
- ☐ High Blood Pressure
- ☐ Kidney Stones/Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Psychiatric Disorder
  - ☐ Bipolar Disorder ☐ Depression
  - ☐ Obsessive/Compulsive ☐ Schizophrenia
- ☐ Stroke
- ☐ Thyroid Disorder
  - ☐ Hyperthyroid ☐ Hypothyroid
  - ☐ Goiter ☐ Graves Disease
- ☐ Other ________________________________

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