

AUGUSTA GYN

Obstetrics & Gynecology

New Patient Information

Full Name _____ Nickname _____

Date of Birth _____ Social Security Number _____

Address _____ City/State/Zip Code _____

Home phone number _____ Daytime phone number _____

Cellular phone number _____ Email address _____

Doctor seeing today _____

Have you ever been seen or treated by any of the physicians in this group previous to today's visit? YES NO

If yes, by which physician? _____ When? _____

If no, how did you learn about Augusta GYN? _____

Marital Status ___ single ___ married ___ widowed ___ separated ___ divorced

Patient employed by _____ Phone number _____

Occupation _____

Emergency Contact _____ Phone number _____

Spouse or Responsible Party Information

Spouse or Responsible Party Name _____ Relation to Patient _____

Address _____ City _____ State _____ Zip _____

Home Ph. _____ Cell Ph. _____ SSN _____ Date of Birth _____

Employer Name _____ Phone Number _____

Occupation _____

Primary Insurance Information

Primary Insurance Company _____

Member Name _____ Member ID# _____ SSN # _____

Group Name _____ Group # _____

Relation to Patient _____ Date of Birth _____

Employer Name _____ Phone Number _____

Secondary Insurance Information

Secondary Insurance Company _____

Member Name _____ Member ID# _____ SSN # _____

Group Name _____ Group # _____

Relation to Patient _____ Date of Birth _____

Employer _____ Phone Number _____

Reason for this visit _____

Please list any medical problems and history of hospitalizations

Illness/Chronic Medical Problems

Year of diagnosis/hospitalization

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any surgeries and their dates

Surgery

Year

_____	_____
_____	_____
_____	_____
_____	_____

First day of last menstrual period _____

When was your last pap smear? _____ Result _____

Any history of abnormal pap smears? Yes No If yes, when? _____ Treatment _____

Please indicate vaccinations you have received and when

Hepatitis B Yes No If yes, when? _____

HPV (human papillomavirus) Yes No If yes, when? _____ All three doses? Yes No

Tdap (tetanus/pertussis protection) Yes No If yes, when? _____

Other and when: _____

Have you had a blood transfusion? Yes No If yes, when? _____

Any history of sexually transmitted diseases (STDs)? Yes No

If yes, please name _____

Are you sexually active? Yes No

If yes, what method of contraception (birth control) do you use? _____

Have you had any miscarriages? Yes No If yes, how many? _____

Have you ever had any ectopic pregnancies? Yes No If yes, how many? _____

Have you had any children? Yes No If yes, please give the year and manner in which he/she was born.

<u>Year</u>	<u>PreTerm?</u>	<u>Vag /Cesarean</u>	<u>Weight/Sex</u>	<u>Complications</u>
_____	_____	_____	_____/____	_____
_____	_____	_____	_____/____	_____
_____	_____	_____	_____/____	_____
_____	_____	_____	_____/____	_____

When was your last mammogram? _____ Result _____

Have you ever had a colonoscopy? Yes No If yes, result _____

Have you ever had a bone density scan? Yes No If yes, result _____

Do you smoke? Yes No If yes, # per day _____ # years _____

Have you smoked previously? Yes No If yes, # years smoked _____ year quit _____

Do you drink alcohol? Yes No If yes, frequency and amount _____

Have any family members had

	<u>Yes/No</u>	<u>Family Member</u>	<u>Maternal or Paternal</u>
High blood pressure?	_____	_____	_____
Cancer? Type?	_____	_____	_____
Diabetes?	_____	_____	_____
Heart attack?	_____	_____	_____
Stroke?	_____	_____	_____
Blood clots in the leg or lungs?	_____	_____	_____
Genetic disease?	_____	_____	_____
Birth defects or mental retardation?	_____	_____	_____

Please list your primary care and other physicians.

Please list your medications and dosage. Include over the counter medications, vitamins, and supplements.

Name

Dosage

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies to medications.

Medication

Reaction

_____	_____
_____	_____
_____	_____

Consent:

I hereby authorize and consent to examinations, treatment, release of medical information to my insurance company(ies), claim representatives, adjustor and other physicians by Augusta GYN, PC. I hereby assign all payments for medical services rendered to Augusta GYN, PC. I understand that my demographic information is stored in the University Health Care System Data Repository.

Patient Signature _____ Date _____