



Name: \_\_\_\_\_ Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Social Security No: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Phone : \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone : \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Local Pharmacy \_\_\_\_\_ Address (Cross Streets): \_\_\_\_\_ Phone: \_\_\_\_\_

Is it OK to leave medical information on your answering machine or voicemail?  YES  NO

You authorize us to share your Protected Health Information with the following person(s) (until you notify us otherwise):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Please carefully read and sign both statements below:**

It is understood that I, or we, will be responsible for all charges incurred on this account, to include all present and future services. I understand that regardless of the insurance coverage that I may have, I am responsible for paying all charges. In event of non-payment of charges for the services rendered, I agree to pay all costs of collection, including reasonable attorney's fees. I have read this agreement and do understand its provisions.

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Women's Health Now to send me newsletters, bulletins, and other documents via email. I understand the Women's Health Now will not share my email address with any other person or agencies with my express written consent. This authorization will remain in effect until I revoke this authorization.

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_



# Obstetrical Patient Medical Information Check-in Sheet

Patient Name: \_\_\_\_\_

### Personal Health History

1. Are you allergic to any medication? \_\_\_\_\_  
If yes, please list and reaction:

\_\_\_\_\_

2. Do you have any NON DRUG allergies? \_\_\_\_\_ If yes, please list:

\_\_\_\_\_

3. Please mark any condition that you have or have had in the past:

Have you ever had:	Yes/Date Diagnosed		Yes/Date Diagnosed		Yes/Date Diagnosed
Epilepsy		Kidney Disease		Gonorrhea	
Heart Disease		Hepatitis		Chlamydia	
Heart Attack		Thyroid Disorder		Syphilis	
Heart Murmur		Bowel Disease		Genital Herpes	
Stroke		Arthritis or Lupus		HIV/AIDS	
Blood Disease		Depression		Recurrent Urinary Tract Infections	
Blood Clots		High Blood Pressure		Bacterial Vaginosis (BV)	
Anemia		Scarlet Fever		Scarlet Fever	
Diabetes		Chicken Pox		Syphilis	
Asthma		Rheumatic Fever		Trichomonas	
Migraine		Type of Cancer		Pelvic Inflammatory Disease (PID)	
Headaches				Human Papillomavirus (HPV)	
Other		Breast Cancer			

4. Please indicate any surgeries that you have had and list dates:

\_\_\_\_\_

5. Please describe any health problems or symptoms that you are having at this time:

\_\_\_\_\_

6. Have you ever been hospitalized? \_\_\_\_\_ If yes, for what?

\_\_\_\_\_

### Exposures Affecting Health

1. Do you smoke cigarettes? \_\_\_\_\_ If yes, how many per day? \_\_\_\_\_

2. Do you drink alcoholic beverages? \_\_\_\_\_ If yes, how often? \_\_\_\_\_  
What type of drink(s)? \_\_\_\_\_

3. Please list any medications that you are taking and dosages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please list any "recreational drugs" used since your last period: (i.e. cocaine, marijuana, etc.)

\_\_\_\_\_

5. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?

\_\_\_\_\_

6. Please list any sources of chemical or radiation exposure that you encounter:

\_\_\_\_\_

7. If you are on a restricted diet, please describe:

\_\_\_\_\_

**Pregnancy History**

Total Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Date of Delivery	Number of Weeks	Vaginal, C-Section or Miscarriage, Abortions	Baby's Weight at Delivery

**Social History**

Marital Status     Married     Single     Divorced     Widowed

- Are you sexually active? \_\_\_\_\_
- Monogamous? \_\_\_\_\_
- Sexual Preference     Male                       Female
- Do you use caffeine? \_\_\_\_\_      If yes, how many cups/drinks per day? \_\_\_\_\_
- Do you exercise? \_\_\_\_\_      How many times/week? \_\_\_\_\_
- Have you ever been abused?  Yes     No
- Do you feel threatened now?  Yes     No

Other/Comments:

**Gynecological Health History**

- When was your last Pap smear? \_\_\_\_\_     Normal     Abnormal
- Have you ever had an abnormal Pap smear? \_\_\_\_\_ If yes, when and where were you last treated?  
\_\_\_\_\_
- When was your last menstrual period? \_\_\_\_\_

4. Have you ever used an IUD (intrauterine device) for contraception? \_\_\_\_\_ If yes, please indicate when \_\_\_\_\_  
Did you have any problem with the IUD? \_\_\_\_\_ If yes, please describe:  
\_\_\_\_\_
5. Do you have a history of infertility? \_\_\_\_\_ If yes, please describe when and treatment received  
\_\_\_\_\_
6. Please list any other concerns you have related to your past health history:  
\_\_\_\_\_
7. Do you have any religious objections to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusion, etc.):  
\_\_\_\_\_

**Family History and Genetic History**

1. Have either you or the baby's father had a child born with a birth defect?  Yes  No  
If yes, please describe: \_\_\_\_\_
2. Did either you or the baby's father have a birth defect yourselves?  Yes  No  
If yes, please describe: \_\_\_\_\_
3. Please describe any abnormalities that have occurred in children in your family or the baby's father family (for example: mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy, or cystic fibrosis):  
\_\_\_\_\_  
How is the affected child/person related to you? \_\_\_\_\_
4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)?  
 Yes  No  
If yes, have either of you had genetic counseling?  Yes  No  
If yes, have either of you had chromosomal studies?  Yes  No  
Where and results: \_\_\_\_\_
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is of one these backgrounds:  
Jewish ancestry  Yes  No  
If yes, have you had Tay-Sachs screening tests?  Yes  No Date: \_\_\_\_\_ Result: \_\_\_\_\_  
Black  Yes  No  
If yes, have you had Sickle Cell Screening?  Yes  No Date: \_\_\_\_\_ Result: \_\_\_\_\_
6. Please mark if anyone in your family or the baby's father family has:  
Diabetes  Yes  No If yes, how is that person related to you? \_\_\_\_\_  
Bleeding Disorder  Yes  No If yes, how is that person related to you? \_\_\_\_\_  
Hypertension  Yes  No If yes, how is that person related to you? \_\_\_\_\_  
Cancer  Yes  No If yes, how is that person related to you? \_\_\_\_\_
7. Please list any other concerns you have about birth defects or inherited disorders:  
\_\_\_\_\_
8. Will you be 35 or older at the time the baby is born?  Yes  No
9. Will the father be 50 or older?  Yes  No

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date