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:_____

ID Number:_____ _Group Number_____

Policy Holder's Name:_____

DOB:____/_____/_____ Social Security No:____-___-___

Secondary Insurance:_____

ID Number:_____ _Group Number_____

Policy Holder's Name:_____

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 Headaches		Type of Cancer		Pelvic Inflammatory Disease (PID)	
Other		Breast Cancer		Human Papillomavirus (HPV)	

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

1. Are you sexually active? _____
2. Monogamous? _____
3. Sexual Preference ☐ Male ☐ Female
4. Do you use caffeine? _____ If yes, how many cups/drinks per day? _____
5. Do you exercise? _____ How many times/week? _____
6. Have you ever been abused? ☐ Yes ☐ No
7. Do you feel threatened now? ☐ Yes ☐ No

Other/Comments:

Gynecological Health History

1. When was your last Pap smear? _____ ☐ Normal ☐ Abnormal

2. Have you ever had an abnormal Pap smear? _____ If yes, when and where were you last treated?

_____

3. 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