Goldsboro Ob-Gyn Associates, P.L.L.C.

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PATIENT / GUARANTOR INFORMATION

Guarantor Section must be completed by the Parent or Legal Guardian for patients less than 18 years of age.

PATIENT FULL NAME: _____

STREET/MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TEL #: _____ CELL #: _____

EMAIL: _____

SSN: _____ DOB: _____

EMPLOYER: _____ WORK TEL #: _____

HOW DID YOU HEAR ABOUT US? *FRIEND OR FAMILY / WEB SEARCH / YELLOW PAGES /* ***OTHER:*** _____

EMERGENCY CONTACT: _____ TEL #: _____

SPOUSE'S FULL NAME: _____

SPOUSE'S SSN: _____ SPOUSE'S DOB: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S WORK #: _____

I understand and agree that, REGARDLESS OF MY INSURANCE STATUS, I am ultimately responsible for the balance on my account for any professional services rendered to me. I have read all the information attached and have completed the above answers. I certify this information is true and correct to the best of my knowledge. If the release of information is necessary for treatment, payment of services provided, or for daily operations, my signature below provides for that request. My signature also allows for any insurance benefits to be assigned to Goldsboro OB-GYN, Associates, P.L.L.C.

_____

PATIENT'S SIGNATURE DATE

_____

SIGNATURE OF PARENT OR GUARDIAN (IF MINOR) DATE

GUARANTOR INFORMATION SECTION

PARENT/GUARDIAN FULL NAME: _____

PARENT/GUARDIAN SSN: _____ PARENT/GUARDIAN DOB: _____

PARENT/GUARDIAN EMPLOYER: _____ WORK TEL#: _____

PARENT/GUARDIAN HOME TEL#: _____ CELL #: _____

NAME: _____ DATE: _____

AGE: _____ LAST PERIOD STARTED: _____

REASON FOR APPOINTMENT: _____

_____

REFERRED BY: _____

PLEASE TAKE YOUR TIME AND READ THE QUESTIONS VERY CAREFULLY.

Circle any of the following problems if you now have them, or if you have ever been treated for; **if you're not sure whether to include something, please put it down.**

High blood pressure	Lung disease (asthma, bronchitis, pneumonia, TB, other)	Varicose Veins
Heart disease	Thyroid disease or goiter	Blood clots in veins
Diabetes	Kidney disease	Anemia
Cancer	Bladder infections	Seizures
Arthritis	Ulcers	Breast lump or cancer
	Liver disease	Nipple discharge
	Nerve disease or Mental disease	Blood transfusions
	VD (gonorrhea, syphilis, herpes, chlamydia, other)	Abnormal pap smears

Any other problems: _____
_____
_____

HOSPITALIZATIONS: Please list all admissions to the hospital, except those listed in surgery. You do not have to list childbirth, we'll ask about that later. If you're not sure of the date or reason, put something down and we'll discuss it.

DATE ILLNESS HOSPITAL PROBLEMS

_____

_____

_____

SURGICAL HISTORY: Please list all your surgeries. Include minor surgery such as D & C, teeth pulled, tubal sterilization, or Cesarean Sections; if you're not sure what was done or how to spell it, do your best. We will go over this with you at your appointment. If you're not certain whether to include something, put it down; it's better to put down too much than to leave something out.

DATE OPERATION HOSPITAL PROBLEMS

_____

_____

_____

MENSTRUAL HISTORY: Please answer all questions in this section even if you no longer have periods or have had a hysterectomy.

How old were you when you began to have period? _____

Are your periods regular? _____

How many days in between your periods? _____(Not counting the bleeding days)

How many days do you bleed? _____

What do you and your partner use for contraception?

_____Pill _____IUD _____Diaphragm _____Foam _____Condoms

__DepoProvera (shot) _____Tubal _____Norplant _____Vasectomy

Other (specify): _____

OBSTETRIC HISTORY: Please answer all questions in this section, even if you no longer have periods or have had a hysterectomy. Start with your first pregnancy; list all pregnancies in order, including any miscarriages and abortions. Problems to list include blood transfusions, infections, C-Sections, etc.

YEAR SEX WEIGHT DID YOU OR THE BABY HAVE ANY PROBLEM?

_____
_____
_____
_____
_____

What medications are you taking or have you taken recently? Please bring all your medications with you.

_____

_____

List any drug allergies, or write "none" if you have no allergies: _____

_____

Do you use tobacco? _____ How much? _____

Do you drink alcohol? _____

Do you use any drugs? _____

Is there any history of cancer of the breast or other cancer in your family? _____

_____

Who? _____

Review of Systems
Please circle any of these problems you are having now:

General:	Chills/fever	Tiredness	Weakness	Weight loss or gain	
Skin:	Rash	Sweaty	Itchy		
Eyes:	Blurred vision	Double vision			
ENT:	Hearing loss	Nose bleeds	Sore throat	Runny nose	Sinus problems
Resp:	Cough	Trouble breathing	Coughing blood		
Cardiac:	Chest pain	Pain in chest with activity		Irregular heartbeats	
GI:	Stomach pain	Constipation	Diarrhea	Nausea	Vomiting
	Black BM's	Bloody BM's			
GU:	Pain with urination	Urination too often	Waking up at night to urinate _____ times		Unable to hold urine
MS:	Back pain	Joint pain	Muscle aches		
Neuro:	Seizures	Dizziness	Passing out	Numbness	Loss of strength
Psych:	Anxiety	Depression	Suicidal thoughts		
Endo:	Excessive thirst	Heat/cold intolerance		Rapid heart beat	
Heme:	Bruising				

Any other problems not listed above? _____

_____

_____

SIGNATURE DATE