



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

2608 Hospital Road • Goldsboro, N.C. 27534 • 919-735-3464 • Fax 919-735-0080

## **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:**

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

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Any other problems not listed above? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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SIGNATURE

DATE

OB HISTORY QUESTIONNAIRE

1. On what date did your last menstrual period start? If unsure, give your best guess. \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions with “yes” or “no”.

2. Have you, the baby’s father, or someone in either of your families, had any of the following disorders?

- a. Down’s syndrome? \_\_\_\_\_
- b. A spinal cord or skull defect? \_\_\_\_\_
- c. A heart defect that required surgery or medical treatment? \_\_\_\_\_
- d. Hemophilia? \_\_\_\_\_
- e. Muscular dystrophy? \_\_\_\_\_
- f. Cystic fibrosis? \_\_\_\_\_
- g. Huntington’s disease? \_\_\_\_\_
- h. Sickle cell trait or disease? \_\_\_\_\_
- i. Mental retardation? \_\_\_\_\_
- j. Autism? \_\_\_\_\_
- k. Any other chromosome or genetic defect? \_\_\_\_\_
- l. Any other birth defects? \_\_\_\_\_

3. Do you have any allergies to medication? \_\_\_\_\_

- a. What kind of reaction did you have? \_\_\_\_\_

4. Are you or the baby’s father Jewish? \_\_\_\_\_

5. Are you or the baby’s father Black? \_\_\_\_\_

6. Are you or the baby’s father of Italian, Greek, or Mediterranean background? \_\_\_\_\_

7. Are you or the baby’s father of Philippine or Southeast Asian background? \_\_\_\_\_

8. Have you ever lived with or had sexual relations with someone who had hepatitis or had a positive test for AIDS virus? \_\_\_\_\_

9. Have you ever been rejected as a blood donor? \_\_\_\_\_

10. Have you ever used IV drugs or had sex with someone who did use them? \_\_\_\_\_

11. Do you have any tattoos or body piercings? \_\_\_\_\_

12. Have you ever worked in a healthcare setting? \_\_\_\_\_

13. Have you had or do you live with someone undergoing renal dialysis? \_\_\_\_\_

14. Have you ever been a resident in or worked in a mental health institution? \_\_\_\_\_

15. Have you had more than 5 lifetime sexual partners, or been treated for syphilis, gonorrhea, herpes, genital warts, (HPV), or chlamydia? \_\_\_\_\_

16. Have you ever had sex with a homosexual or bisexual man? \_\_\_\_\_

17. Have you ever had chicken pox? \_\_\_\_\_ Fever blisters or cold sores? \_\_\_\_\_ Shingles? \_\_\_\_\_