NEW YORK OB/GYN™ ASSOCIATES

Date______________

Patient Information

Name____________ Last Name:____

Date of Birth: ____________________ Social Security # _________________________

Address: ____

Home Phone Number:____________ May we leave a voice message? Yes___ No_____

Marital Status: ____________________

Employment: _____________________

Employer Name: ____

May we contact you at work? Yes ___________ No___________

May we email test results? Yes ___No_____ Email Address: ______________________

May we discuss your medical/financial information with anyone? Yes ______ No_____

If so, with whom? (First and Last Name required)________________________________

How did you hear about our office?____

If referred by a doctor or clinic please give the name, address & phone number________

____

Race (optional):

Caucasian_____ African American_____Hispanic____Asian____Indian____Other ____

In Case of Emergency

Name:____

Relationship:____

Home Phone_________________________ Office Phone__________________________

Does this person know the reason for your visit to our office?

Yes_____________ No_____________

Is this person here with you today? ____

Insurance Information

Insurance Company:____

Policy Number:_______________________ Group Number:_______________________

Self:____ Spouse:____________________

If Policy holder is NOT yourself, please supply the following information about the

Policy holder: _____________________________________Social Security # __________

Additional Information:____

Health History Questionnaire

Date of last Pap smear_____________ What was the first day of your last normal menstrual period?_____________ How old were you when you first started your period?______________ Which method of birth control have you used in the past?_______________ What form of birth control do you use at the present time? How many children do you have? How many miscarriages? How many abortions? Do you need birth control or contraceptive advice? **Yes** ___ **No** ___ Have you ever had an abnormal pap smear? **Yes** ___ **No** ___ Have you ever had cryosurgery? **Yes** ___ **No** ___ (freezing of the cervix)	Do you have any history of the following Herpes Infection **Yes** ___ **No** ___ Tubal/Ovarian infection **Yes** ___ **No** ___ Gonorrhea **Yes** ___ **No** ___ Syphilis **Yes** ___ **No** ___ Chlamydia **Yes** ___ **No** ___ Condylonma (HPV) **Yes** ___ **No** ___
Are your periods irregular? **Yes** ___ **No** ___	Do you have cyclic breast pain? **Yes** ___ **No** ___
Do you often skip periods? **Yes** ___ **No** ___	Do you have a history of breast lumps or tumors? **Yes** ___ **No** ___
Do you have heavy bleeding with your period? **Yes** ___ **No** ___	Do you have any milk or discharge from your breasts? **Yes** ___ **No** ___
Do you have pain with your period? **Yes** ___ **No** ___ If so is it Mild Moderate or Severe?	Do you perform self breast examinations? **Yes** ___ **No** ___
Do you have pain during or after intercourse? **Yes** ___ **No** ___	Do you have a family history of breast cancer? **Yes** ___ **No** ___
Are you having any problems during or after sex? **Yes** ___ **No** ___ If so please explain___________________________	Have you ever had a mammogram? **Yes** ___ **No** ___ Do you lose urine when lifting heavy objects or coughing? **Yes** ___ **No** ___
Are you trying to become pregnant? **Yes** ___ **No** ___	Do you have involuntary loss of urine? **Yes** ___ **No** ___
Did your mother take hormones during pregnancy? **Yes** ___ **No** ___ If so which ones?___________	Do you experience bladder symptoms of urgency, frequency, or pain? **Yes** ___ **No** ___
Have you ever had problems with anesthesia? **Yes** ___ **No** ___	Do you smoke? **Yes** ___ **No** ___ If so how many packs a day?
Have you ever been hospitalized or have had surgery? **Yes** ___ **No** ___	How much alcohol do you consume weekly?
Have you consumed drugs or alcohol in the past 24 hours? **Yes** ___ **No** ___ If so please explain____________________	How many cups of coffee, cokes or glasses of tea do you consume daily?
Do you have a history of drug or alcohol abuse? **Yes** ___ **No** ___ Are you allergic to (circle) seafood, Latex, Iodine, Novacaine or Lidocaine? If so what type of reaction do you experience? _____________	Are you allergic to any drugs or medications? If yes please list them:

Do you have: Dentures? **Yes** ___ **No** ___ Loose teeth? **Yes** ___ **No** ___ Contact lenses? **Yes** ___ **No** ___ Tongue ring? **Yes** ___ **No** ___	

Previous Pregnancies

#of	Type	Year of Most Recent	Comments/Complications
	Vaginal Delivery		
	Cesarean		
	Tubual/Ectopic Pregnancy		
	Miscarriage		
	Abortion		
	Twins or Triplets		

Review of Medical History

Have you ever experienced any of the following diseases, illnesses, surgical procedures?

Condition	Yes	No
Abdominal surgery		
Arthritis		
Anemia		
Appendectomy		
Asthma		
Bleeding (excessive)		
Blood clot in vein(phlebitis)		
Blood transfusions		
Breast pain		
Breast Lump/Tumor		
Broken Bones		
Cancer:		
Genital		
Breast		
Other:_______		
Chest pain		
Chlamydia		
Concussion/Head Injury		
Colposcopy		
Colitis		
Coronary artery disease		
D&C		
Diabetes		
Discharge(vaginal)		
Dizzy/fainting spells		
Emphysema/Bronchitis		
Epilepsy, seizures, convulsion		
Fibroid tumor		
Gallbladder disease/stones		

Condition	Yes	No
Dizzy/fainting spells		
Emphysema/Bronchitis		
Epilepsy, seizures, convulsion		
Fibroid tumor		
Gallbladder disease/stones		
Gonorrhea		
Headaches (frequent or severe		
Head/Neck Surgery		
Heart disease, murmur		
Heart problems		
Heart/Lung Surgery		
Hepatitis, liver disease		
Herpes		
High blood pressure (hypertension)		
High cholesterol		
Hysteroscopy		
Hysterectomy		
Infection of uterus/ovary/tubes		
Kidney disease		
Laparoscopy		
Ovarian cyst		
Pneumonia		
Psychiatric problems		
Pulmonary lung disease		
Rheumatic fever		
Sickle Cell anemia		
Sickle cell trait		
Stroke		
Stomach Ulcer		

Gonorrhea	**Yes** ___ **No** ___	Surgery of fallopian tubes or ovaries	**Yes** ___	**No** ___
		Syphilis	**Yes** ___	**No** ___
		Thyroid problem	**Yes** ___	**No** ___
		Tonsillectomy	**Yes** ___	**No** ___
		Tuberculosis	**Yes** ___	**No** ___

List any other medical illnesses or surgical procedures______________________________
____
____

List all present medications____
____
____

List all allergies____
____
____

Family Medical History

Heart Disease_____________
Stroke____________
High Blood Pressure___________
Diabetes______________
Cancer_____________

I request and consent to the performance of service rendered by New York OB/GYN Associates™. I consent to the taking of cultures and the performance of reasonable indicated tests and procedures including ultrasounds, whether or not relating to presently known conditions, if my physician determines that they are necessary.

Assignment of Benefits
I hereby assign all medical and/ or surgical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plan to NEW YORK OB/GYN ASSOCIATES™ This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment

Final Agreement
I __________________________________ agree to assume responsibility for balance due of services rendered that would not be covered under a contracted insurance agreement that New York OB/GYN Associates™ in contracted with.

Signature______________________ Date________________________