Do you have an Advance Directive?
☐ YES ☐ NO
Do you want information regarding Advance Directive? ☐ YES ☐ NO

OB/GYN
PATIENT OFFICE RECORD

Preferred Pharmacy
_____
Location _____

PHYSICIAN_____ALLERGIES_____ HEIGHT_____ DATE: _____

PATIENT INFORMATION: (Please Print)

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Address _____

City: _____ State: _____ Zip Code: _____

SSN# _____ DL#_____ Religion _____ Ethnicity _____

Home Phone: _____ Cell Phone: _____ Marital Status:_____

Email Address:_____

EMPLOYER INFORMATION:

Employer: _____ Phone: _____

Address _____

City: _____ State: _____ Zip Code: _____

SPOUSE OR PARENT INFORMATION:

Name: _____ SSN# _____ Date of Birth: _____

Employer & Address: _____

Home Phone: _____ Business Phone: _____

FRIEND OR RELATIVE NOT LIVING WITH YOU:

Name: _____ Relationship_____ Phone_____

Address _____

INSURANCE INFORMATION:

Name of Ins. Co.: _____ Policy ID#_____ Group#_____

Name of Insured:_____ SSN#_____ DOB:_____ Relationship to Patient:_____

Address of Insured/Patient if not self:_____ Tel. #of Insured:_____

Name of Ins. Co.: _____ Policy ID#_____ Group#_____

Name of Insured:_____ SSN#_____ DOB:_____ Relationship to Patient:_____

Address of Insured/Patient if not self:_____ Tel. #of Insured:_____

TENNCARE: **MEDICARE:**

_____Yes _____No ID#_____ _____Yes _____No ID#_____

PRIMARY CARE PHYSICIAN:

_____ Referred by:_____

Privacy Notice: My signature verifies that I have received a copy of OB/GYN Associates Privacy Notice. I understand my signature also allows OB/GYN Associates to mail, fax, or electronically transmit protected health information regarding me for purposes of payment, treatment, and healthcare operations.

Signature of patient or guardian:_____ Date: _____

Payment Agreement: I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to the providers of OB/GYN Associates. I also permit a copy of this authorization to be used in the place of the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all the charges whether or not paid by said insurance, I AGREE to pay 33% of the principal balance for collections costs should my account be placed with a collections agency or attorney plus court cost expended.

Signature of patient or guardian:_____ Date: _____

OB/GYN Associates, P.C.
317 North Hickory Avenue
Cookeville, Tennessee 38501

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I give permission for OB GYN Associates to discuss my Protected Health Information with the person(s) listed below. Protected Health Information includes but is not limited to diagnosis, current treatment, future treatment, appointments, medications, billing and insurance issues. I understand it is my responsibility to update or make changes to this form if the information below changes at any time during my care with OB GYN Associates.

NAME	RELATIONSHIP & PHONE NUMBER
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

** _____ PLEASE DO NOT RELEASE/DISCUSS ANY PROTECTED HEALTH INFORMATION WITH ANYONE EXCEPT ME.

_____ _____
Patient or Legal Guardian Signature Date

Patient's Date of Birth _____
Anyone calling to discuss your Protected Health Information must be on this list and must be able to give us the "Patient's Date of Birth" as indicated on this form.

GYNECOLOGIC INTAKE HISTORY

NAME:_____BIRTHDATE:___/___/_____ AGE:_____ DATE:___/___/_____

NAME OF SPOUSE/PARTNER:_____ REFERRED BY:_____

RELIGION:_____ OCCUPATION:_____ RACE:_____

Age at first period?_____ Date of last period_____

Current Contraception_____ Date of last Pap Smear_____

Date of last mammogram_____

Please ☑ if you have any of these symptoms

- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ Bad menstrual cramps
- ☐ Bleeding Disorder
- ☐ Bleeding with intercourse
- ☐ Painful intercourse
- ☐ Not sexually active
- ☐ Vaginal discharge
- ☐ Menopausal Bleeding
- ☐ Previous abnormal Pap
- ☐ Difficulty getting pregnant

1. Constitutional
   - ☐ Weight loss
   - ☐ Weight gain
   - ☐ Fever
   - ☐ Fatigue
2. Eyes
   - ☐ Double Vision
   - ☐ Spots before eyes
   - ☐ Vision changes
3. ENT/Mouth
   - ☐ Ear aches
   - ☐ Ringing in ears
   - ☐ Sinus problems
   - ☐ Sore throat
   - ☐ Mouth sores
   - ☐ Dental problems
4. Cardiovascular
   - ☐ Painful breathing
   - ☐ Chest pain
   - ☐ Difficult breathing on exertion
   - ☐ Swelling of legs
   - ☐ Palpitations of heart
5. Respiratory
   - ☐ Wheezing
   - ☐ Spitting/cough up blood
   - ☐ Shortness of breath
   - ☐ Chronic cough
6. Gastrointestinal
   - ☐ Diarrhea, frequent
   - ☐ Bloody stool
   - ☐ Nausea/Vomiting
   - ☐ Constipation
   - ☐ GERD
7. Urinary Symptoms
   - ☐ Blood in urine
   - ☐ Pain with urination
   - ☐ Urgency
   - ☐ Difficulty voiding
   - ☐ Urine loss with cough
8. Musculoskeletal
   - ☐ Muscle weakness
9. Skin/Breast
   - ☐ Pain in breast
   - ☐ Discharge
   - ☐ Masses
   - ☐ Rash
10. Neurological
    - ☐ Dizziness
    - ☐ Seizures
    - ☐ Numbness
11. Psychiatric
    - ☐ Depression
    - ☐ Crying, frequent
12. Endocrine
    - ☐ Dry skin
    - ☐ Abnormal thirst
13. Hematological/Lymphatic
    - ☐ Bruises, frequent
    - ☐ Cuts do not stop bleeding
    - ☐ Enlarged lymph nodes

Notes:

- ☐ Have you had a persistent cough more than 3 weeks?
- ☐ Have you been coughing up bloody sputum (saliva)?
- ☐ Night Sweats? Weight Loss? Fever? Loss of Appetite?

Allergies:

Drugs _____

Other_____

3/27/2012

PAST PERSONAL HISTORY Patient Name_____ Chart no._____

OB History		
	Number	Unusual Problems in Pregnancy:
Total pregnancies		
Full term		
Premature		
Miscarriages/abortions		
Living children		
Previous cesarean sections		

MAJOR ILLNESSES	
☐ Asthma	☐ Cancer
☐ Pneumonia	☐ Ulcers
☐ Chronic Lung Disease	☐ Depression/anxiety
☐ Kidney Infections/stones	☐ Anemia/Blood transfusions
☐ Tuberculosis	☐ Seizures/convulsions/epilepsy
☐ Venereal Disease	☐ Bowel trouble
☐ Heart Trouble/murmur	☐ Glaucoma
☐ Diabetes	☐ Arthritis/joint pain
☐ High Blood Pressure	☐ Fracture
☐ Stroke	☐ Hepatitis/Yellow jaundice
☐ Rheumatic Fever	☐ Thyroid Disease
Use space below for others not listed:	☐ Phlebitis, pulmonary embolus or blood clots in legs or lungs

Procedures / Operations / Hospitalizations			
	Date	Other Non-OB	Date
☐ Hysterectomy		☐ Tonsils	
☐ Ovaries removed		☐ Appendix	
☐ Cesarean section		☐ Gall Bladder	
☐ Tubal ligation		☐ Laparoscopy	
☐ Urine incontinence procedure		☐ Heart Surgery	
☐ Last Colonoscopy		☐ Last bone density	
☐ Other:		☐ Last Tetanus	
☐ Other:		☐ Other:	

CURRENT MEDICATIONS	

FAMILY HISTORY

Illness	Relation	Illness	Relation
☐ Diabetes		☐ Drinking Problem	
☐ Stroke		☐ Breast Cancer	
☐ Heart Disease		☐ Colon Cancer	
☐ High Blood Pressure		☐ Ovarian Cancer	
Other family history of diseases or birth defects:			

SOCIAL HISTORY Patient Name_____ Chart no._____

CHECK ☑ IF ANY OF THE FOLLOWING APPLY TO YOU:

Habits		
☐ Smoking	Packs per day_____	Years_____
☐ Alcohol	Drinks per day_____	Drinks per week_____
☐ Drug Use		
☐ Seat Belt Use		
☐ Regular Exercise		

Personal Profile				
Marital Status	Married ☐	Single ☐	Widowed ☐	Divorced ☐
Number of people in household _____				
School Completed	High School ☐	College ☐	Graduate Degree ☐	Other ☐

Current or most recent job _____

Personal Safety
☐ Has anyone close to you ever threatened to hurt you?
☐ Has anyone ever hit, kicked, choked, or hurt you physically?
☐ Has anyone, including your partner, ever forced you to have sex?
☐ Are you ever afraid of your partner?

Additional History

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient:_____

Date reviewed by physician with patient:_____

Physician Signature:_____

Additional Reviews of past medical, family, social history and review of systems:

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____ Physician Signature:_____