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: __________ (Last) (First) (Middle) Date of Birth: __________

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:**

_____Yes _____No ID#__________

**MEDICARE:**

_____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** ______________________

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 | |
|---|---|
| | |
| | |
| | |
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| | |
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| | |

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:______________________

# PREGNANCY QUESTIONNAIRE

Name: ______________________ Date ______________

## GENETICS SCREENING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| 1. ARE YOU OLDER THAN 34? | | | 10. HUNTINGTON CHOREA? | | |
| 2. ITALIAN, GREEK, MEDITERRANEAN, OR ORIENTAL BACKGROUND? | | | 11. MENTAL RETARDATION? | | |
| 3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE, OR ANENCEPHALY)? | | | IF YES, WAS PERSON TESTED FOR FRAGILE X? | | |
| 4. DOWN SYNDROME | | | 12. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER? | | |
| 5. JEWISH (TAY-SACHS) | | | 13. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE, 2-3 TRIMESTER SPONTANEOUS ABORTIONS, OR A STILL BIRTH? | | |
| 6. SICKLE CELL DISEASE OR TRAIT? | | | | | |
| 7. HEMOPHILIA? | | | 14. MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD? | | |
| 8. MUSCULAR DYSTROPHY? | | | IF YES, AGENT(S) | | |
| 9. CYSTIC FIBROSIS? | | | | | |

## PRESENT PREGNANCY

HAVE YOU HAD ANY OF THE FOLLOWING DURING THIS PREGNANCY?

| | | | | | |
|---|---|---|---|---|---|
| 1. VAGINAL BLEEDING | | | 6. ABDOMINAL PAIN | | |
| 2. VAGINAL DISCHARGE/ODOR | | | 7. URINARY COMPLAINTS | | |
| 3. VOMITING | | | 8. FEVER | | |
| 4. CONSTIPATION | | | 9. OTHER | | |
| 5. HEADACHE | | | | | |

## PAST PREGNANCIES, INCLUDING MISCARRIAGES AND ABORTIONS

| DATE MO./YR. | FULL TERM YES/NO | LENGTH OF LABOR | BIRTH WEIGHT | TYPE DELIVERY | ANES. | PLACE OF DELIVERY | LIVING CHILD YES/NO | PRETERM LABOR YES/NO | COMMENTS/ COMPLICATIONS |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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## MEDICAL HISTORY

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DIABETES | | | | 15. RH SENSITIZED | | |
| 2. HYPERTENSION | | | | 16. TUBERCULOSIS | | |
| 3. HEART DISEASE | | | | 17 ASTHMA | | |
| 4. RHEUMATIC FEVER | | | | 18. ALLERGIES (DRUGS) | | |
| 5. MITRAL VALVE PROLAPSE | | | | 19. GYN SURGERY | | |
| 6. KIDNEY DISEASE / UTI | | | | 20. HISTORY OF BLOOD TRANSFUS. | | |
| 7. NEUROLOGIC / EPILEPSY | | | | 21. OPERATIONS / HOSPITALIZATIONS (YEAR & REASON) | | |
| 8. PSYCHIATRIC | | | | | | |
| 9. HEPATITIS / LIVER DISEASE | | | | | | |
| 10. VARICOSITIES / PHLEBITIS | | | | 22. ANESTHETIC COMPLICATIONS | | |
| 11 THYROID DYSFUNCTION | | | | 23. HISTORY OF ABNORMAL PAP | | |
| 12. MAJOR ACCIDENTS | | | | 24. UTERINE ANOMALY | | |
| | | AMT/DAY PREG. | YEARS USE | 25. IN UTERO DES EXPOSURE | | |
| 13. TOBACCO | | | | 26. INFERTILITY | | |
| 14. ALCOHOL | | | | 27. STREET DRUGS | | |

Genetic Screening/Teratology Counseling
(includes patient, baby's father, or anyone in either family)
Circle YES or NO

Name of Patient: ______________________________ Date of Birth: __________________

1. Patient's age >/= 35 at due date? **YES** **NO**
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV<80? **YES** **NO**
3. Neural Tube defect (meningomyelocele, spina bifida, anencephaly)? **YES** **NO**
4. Congenital heart defect? **YES** **NO**
5. Down syndrome? **YES** **NO**
6. Tay-Sachs (Jewish, French Canadian)? **YES** **NO**
7. Canavan's Disease? **YES** **NO**
8. Sickle cell disease or trait (African)? **YES** **NO**
9. Hemophilia or other blood disorder? **YES** **NO**
10. Muscular dystrophy? **YES** **NO**
11. Cystic fibrosis? **YES** **NO**
12. Huntington's chorea? **YES** **NO**
13. Mental retardation/autism (if yes was person tested for Fragile X)? **YES** **NO**
14. Other inherited genetic or chromosomal disorder? **YES** **NO**
15. Maternal metabolic disorder (DM, PKU, etc)? **YES** **NO**
16. Patient or father of baby with a birth defect not listed above? **YES** **NO**
17. Patient or father of baby with birth defect themselves? **YES** **NO**
18. Recurrent pregnancy loss or stillbirth? **YES** **NO**
19. Any medication since LMP other than prenatal vitamins (include vitamins, supplements, OTC medications, drugs and/or alcohol)? **YES** **NO**
20. Any other genetic/environmental exposure to discuss? **YES** **NO**
21. Do you have indoor or outdoor cats? **YES** **NO**
22. Have you had chicken pox? **YES** **NO**
23. Are you exposed to children? **YES** **NO**

**Infection History:**

1. Lives with someone with TB or TB exposed? **YES** **NO**
2. Patient or partner has history of genital herpes? **YES** **NO**
3. Rash or viral illness since LMP? **YES** **NO**
4. History of STD (GC, CT, HPV, syphilis, HIV)? **YES** **NO**
5. Hepatitis C? **YES** **NO**

**OTHER:**

______________________________________________________________________

______________________________________________________________________