Eastside OB/GYN

(Please circle name of doctor you are seeing)

Bell Rainwater Street Hill

Date: ____________________

Name: ____ Maiden/Previous: ____________________ Sex: __________

Last First Middle Initial

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Date of Birth: ____________________ Social Security Number: ____________________ Race: __________

Address: ____

City State Zip

Home Phone: ____________________ Cell: ____________________

Work Phone: ____________________ Employer: ____________________

Emergency Contact other than <u>spouse or home:</u>

Name: ____________________ Relationship: ____________ Phone: ____________________

Spouse or Responsible Party (If dependent under 18 years of age):

Name: ____ Date of Birth: ____________________

Social Security Number: ____________________ Relationship to Patient: ____________________

Employer: ____________________ Cell Phone: ____________________

Insurance Coverage Information (Please fill out completely and have card available for us to copy)

____________________ / ____________________ / ____________________

Name of **primary** coverage Group or Policy Number Member ID Number

____________________ / ____________________ / ____________________

Name of person carrying insurance Social Security Number Date of Birth

Relationship to Patient: ____________________ Employer: ____________________

____________________ / ____________________ / ____________________

Name of **secondary** coverage Group or Policy Number Member ID Number

____________________ / ____________________ / ____________________

Name of person carrying insurance Social Security Number Date of Birth

Relationship to Patient: ____________________ Employer: ____________________

Who referred you to our office? ____

I understand and acknowledge that it is my responsibility to determine whether or not my insurance company (or companies) requires precertification or a second opinion on surgeries or obstetrical care. I also understand and acknowledge that if the above is required, I will contact the proper department of the insurance company and determine what action is necessary. I also understand that the contract is between myself and the insurance company, and that if the insurance company does not pay then any balance is my responsibility.

____ ____________________

Patient Signature Date

Patient Name: ______________________________

Reason for today's visit? ☐ Yearly Exam ☐ Pregnant ☐ Problem: ______________
Last period began: ____________ Period occur about every ________days, lasting ________Days
Number of: Pregnancy ________ Delivery ________ Miscarriage________ Abortion________
Do you smoke? _____ If YES, How much? _______ Alcohol________ How often?_______ Drugs_______
Drug Allergies: ☐None ☐Penicillin ☐Amoxicillin ☐Sulfa ☐Keflex ☐Erythromycin
☐Other:______________________________

Current Medications (Name, dose, and how often; include Birth Control Pills):______________
____
____

Have you ever had any operations? (check those that apply)
☐Tonsils ☐Appendix ☐D&C ☐C-Section ☐Tubal Ligation ☐Heart Bypass
☐Hysterectomy with ☐None, ☐One, or ☐Both Ovaries removed ☐Angioplasty
☐Arthroscopy of knee/shoulder ☐Right ☐Left ☐Both ☐Back Surgery ☐Gallbladder
☐Mastectomy ☐Right ☐Left ☐Lumpectomy ☐Right ☐Left ☐Breast Biopsy ☐Right ☐Left
☐Other:______________________________

Past Medical Problems (circle those that apply)
☐Stroke ☐Seizures ☐Migraines ☐Diabetes ☐High Blood Pressure ☐Hepatitis
☐Underactive Thyroid ☐Overactive Thyroid ☐Rheumathoid Arthritis ☐Stomach Ulcers
☐Rheumatic Heart Disease ☐Blood Clots ☐Asthma ☐Heart Attack ☐Tuberculosis
☐Peripheral Vascular Disease ☐Irritable Bowel Syndrome ☐Spastic Colon ☐Gallstones
☐Rheumatic Fever ☐Lupus ☐Kidney Infections ☐Kidney Stones ☐Anemia
☐Pregnancy Problems (☐multiple miscarriages, ☐preterm labors, ☐high blood pressure)
☐Cancer of ______________________________
☐Other______________________________

Family Medical History
How many sister did/do you have?______ How many brother did/do you have? ______
Mother: ☐Diabetes ☐High Blood Pressure ☐Cardiac ☐Thyroid
Father: ☐Diabetes ☐High Blood Pressure ☐Cardiac ☐Thyroid
Sister: ☐Diabetes ☐High Blood Pressure ☐Cardiac ☐Thyroid
Brother: ☐Diabetes ☐High Blood Pressure ☐Cardiac ☐Thyroid
Does any female disease/condition run in your family? ______________________________
Has anyone in your family had a problem with blood clots? ______________________________

Is there something in your medical history that we need to know not covered above?____________
____
____

Eastside OB/GYN Dr. Laws

Name: ______________________________ Maiden/Previous: ____________ Sex: ________
Last First Middle Initial

Marital Status: Single☐ Married☐ Divorced☐ Widow☐ Other _______________

Date of Birth: _________ Social Security Number: __________________ Race: _______

Address: ____
City State Zip

Home Phone: ________________ Cell: __________________

Work Phone __________________ Employer: __________________________

Emergency Contact other than spouse or home:

Name: ________________ Relationship: ____________ Phone: _______________

Spouse or Responsible Party (If dependent under 18 years of age)

Name: _________________________ Date of Birth: _______________________

Social Security Number: _______________ Relationship to Patient: _________________

Employer: ______________________ Work Phone: _______________________

Insurance Coverage Information (***Please fill out completely and have card available for us to copy***)

_______________________ / ____________________ / ____________________
Name of primary coverage Group or Policy Number Member ID Number

_______________________ / ____________________ / ____________________
Name of person carrying insurance Social Security Number Date of Birth
Relationship to Patient: __________________ Employer: ____________________

_______________________ / ____________________ / ____________________
Name of secondary coverage Group or Policy Number Member ID Number

_______________________ / ____________________ / ____________________
Name of person carrying insurance Social Security Number Date of Birth
Relationship to Patient: ____________________ Employer: ____________________

Who referred you to our office? ____

I understand and acknowledge that it is my responsibly to determine whether or not my insurance company (or companies) requires precertification or second opinion on surgeries or obstetrical care. I also understand and knowledge that if the above is required, I will contact the proper department of the insurance company and determine what action is necessary. I also understand that the contract is between myself and the insurance company, and that if the insurance company doesn't pay then any balance is my responsibility.

________________________________ ______________________
Patient Signature Date

Eastside OB/GYN Dr. Laws

Past Medical, Social and Family History

Patient's Personal Medical History:

Reason for today's visit: ______________________________

□Heart Attack □Stent placement □CABG (Bypass Graft) □High Blood Pressure □Hard of hearting
□CHF (Congestive Heart Failure) □COPD (Obstructive Pulmonary Disease □Thyroid Disease
□Asthma □Bronchitis (Chronic) □Shortness of Breath □Hepatitis □Diabetes
□Pneumonia □Sleep Apnea □Emphysema □Ulcer □Reflux Disease
□Diarrhea (Chronic) □Bowel Irregularity □Chronic Rashes □Eczema □Glaucoma
□Prostate Disease □Pelvic Inflammatory □Headaches □Abnormal Periods □Gallbladder Disease
□Kidney Stones □Seizures □Depression □Dizziness/Fainting
□Nervousness □Anxiousness □Gout □Sexually Transmitted Disease
□Allergies (Chronic) □Arthritis □Anemia □High Cholesterol
□Cancer: ______________ □Other Comments______________________________
*List All Surgeries:____
____

Do you see any other doctor for anything?

□Allergist □Cardiologist □Dermatologist □ENT □Oncologist □Podiatrist
□Gastroenterologist □Neurologist □Neuro Surgeon □Endocrinology □Psychiatrist □Pulmonologist
□Orthopedist □Pediatrician □Plastic Surgeon □Psychologist □Urology □Nephrology
□Rheumatologist □Ophthalmologist □Chiropractor □OB/GYN □Surgeon □Oher______________

Patients' Social History

Women: Are you pregnant? □Yes □No Planning Pregnancy? □Yes □ No Birth Control Method: ______________
Pregnancies: __ How many to term? ___How many C-Section? ___How many miscarriages? ___Date of last period_____
Do you smoke? □Yes □No How much per day? __ Smoked in the past □Yes □No When did you quite? __________
Dip? □Yes □No How much? __ Drink coffee? □Yes □No How much cup(s) per day? ________
Exercise □Yes □No How much? ____________ Method: ______________________
Drink alcohol?□Yes □No *□Only in occasions □Once/twice month □Once/twice weekly □Several times a week □Daily
What type of alcohol? □Wine □Beer □Whiskey Any reactional drug use? □Yes □No What type? ______________
Sleep patterns: ______________________________________

Family Medical History

Heart Disease:	□Mother	□Father	□Sibling	□Grandparent
High blood pressure:	□Mother	□Father	□Sibling	□Grandparent
Stroke:	□Mother	□Father	□Sibling	□Grandparent
Cancer:	□Mother	□Father	□Sibling	□Grandparent Type; ____________
Glaucoma:	□Mother	□Father	□Sibling	□Grandparent
Diabetes:	□Mother	□Father	□Sibling	□Grandparent
Seizures:	□Mother	□Father	□Sibling	□Grandparent
Bleeding Disorder:	□Mother	□Father	□Sibling	□Grandparent
Kidney Disease:	□Mother	□Father	□Sibling	□Grandparent
Mental Disease:	□Mother	□Father	□Sibling	□Grandparent
Thyroid Disease:	□Mother	□Father	□Sibling	□Grandparent
Other:	□Mother	□Father	□Sibling	□Grandparent ____________

Any Drug Allergies □Yes □No Type: ____________________ Current Medications:__________________
____