Eastside OB/GYN

(Please circle name of doctor you are seeing)

Muylaert Laws Bell Rainwater Street Wood

Date: _____

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: _____ 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 is it 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 doesn't 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?_____
_____
_____