Eastside OB/GYN

(Please circle name of doctor you are seeing)

BELL RAINWATER STREET HILL HOUSEHOLDER

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 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:_____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 this 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 the 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_____

Preferred Pharmacy:_____ Primary Care Physician:_____
Date of last: Mammogram_____ Pap_____ Colonoscopy_____
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 (check those that apply)
☐Stroke ☐Seizures ☐Migraines ☐Diabetes ☐High Blood Pressure ☐Hepatitis
☐Underactive Thyroid ☐Overactive Thyroid ☐Rheumatoid 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 sisters did/do you have? _____ How many brothers 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 that is not covered above?_____
_____
_____