

**Obstetrics & Gynecology Associates, P.A.**

specializing in

*Obstetrics, Gynecology, Infertility and Laser Surgery*

**GYNECOLOGIC INTAKE HISTORY**

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 HOME TEL: \_\_\_\_\_ WORK TEL: \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_ INSURANCE: \_\_\_\_\_  
 NAME OF SPOUSE/PARTNER: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

**REVIEW OF SYSTEMS**

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	Currently	Past	Notes
1. <b>Constitutional</b> Weight loss Weight gain Fever Fatigue	_____ _____ _____ _____	_____ _____ _____ _____	
2. <b>Eyes</b> Double vision Spots before eyes Vision changes	_____ _____ _____	_____ _____ _____	
3. <b>ENT/Mouth</b> Ear aches Ringing in ears Sinus problems Sore throat Mouth sores Dental problems	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	
4. <b>Cardiovascular</b> Painful breathing Chest pain Difficulty breathing on exertion Swelling of legs Palpitations of heart	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	
5. <b>Respiratory</b> Wheezing Spitting up blood Shortness of breath Cough, chronic	_____ _____ _____ _____	_____ _____ _____ _____	
6. <b>Gastrointestinal</b> Diarrhea, frequent Bloody stool Nausea / vomiting Constipation	_____ _____ _____ _____	_____ _____ _____ _____	
7. <b>Genitourinary</b> Blood in urine Pain in urination Urgency Frequency of urination Incomplete emptying Stress incontinence Abnormal periods Painful intercourse	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	
8. <b>Musculoskeletal</b> Muscle weakness	_____	_____	
9. <b>Skin / breast</b> Pain in breast Discharge Masses Rash Ulcers	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	

NAME:

DOB:

DATE:

**REVIEW OF SYSTEMS**

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN				
#	System	Currently	Past	Notes
10.	Neurological Dizziness Seizures Numbness Trouble walking	_____ _____ _____ _____	_____ _____ _____ _____	
11.	Psychiatric Depression Crying, frequent	_____ _____	_____ _____	
12.	Endocrine Dry skin Abnormal thirst Hot flashes	_____ _____ _____	_____ _____ _____	
13.	Hematologic / Lymphatic Bruises, frequent Cuts do not stop bleeding Enlarged lymph nodes	_____ _____ _____	_____ _____ _____	
14.	Allergic / Immunologic Allergies Drugs, other	_____ _____	_____ _____	

**PERSONAL PAST HISTORY**

MAJOR ILLNESSES	Yes	No	MAJOR ILLNESSES	Yes	No
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		

**OPERATIONS / HOSPITALIZATIONS**

Reason	Date	Reason	Date

**INJURIES / ILLNESSES**

Reason	Date	Type	Date

**LAST IMMUNIZATION OR TEST**

	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

**OB / GYN HISTORY**

	Number		Number
Births		Abortions	
Miscarriages		Living Children	

**CURRENT MEDICATIONS**

Drug Name	Dosage	Drug Name	Dosage

NAME:

DOB:

DATE:

**FAMILY HISTORY**

ILLNESSES	Yes	Relative	ILLNESSES	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

**SOCIAL HISTORY**

HABITS	Yes	No		
Smoking			Packs per day _____	Years _____
Alcohol			Drinks per day _____	Drinks per week _____
Drug Use				
Seat Belt Use				
Tuberculosis				
Regular Exercise				

**PERSONAL PROFILE**

Marital Status      Married \_\_\_\_\_      Single \_\_\_\_\_      Widowed \_\_\_\_\_      Divorced \_\_\_\_\_

Number of Living Children \_\_\_\_\_

Number of people in household \_\_\_\_\_

School Completed      High School \_\_\_\_\_      College \_\_\_\_\_      Graduate Degree \_\_\_\_\_      Other \_\_\_\_\_

Current or most recent job \_\_\_\_\_

2 of the 3 elements must be met or exceeded to qualify for a given type of medical decision making

Amt / Complexity of Data	Diagnoses / Mgt Options	Risk of Complications	Risk of Complications
Minimal / None	Minimal	Minimal	Minimal
Limited	Limited	Low	Low
Moderate	Multiple	Moderate	Moderate
Extensive	Extensive	High	High

Completed by:      Patient \_\_\_\_\_      Office Nurse \_\_\_\_\_      Physician \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date Reviewed by Physician with Patient: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

**Subsequent Review of History:**

Date reviewed: \_\_\_\_\_      Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_      Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_      Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_      Physician Signature: \_\_\_\_\_

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**REGISTRATION SLIP**

Date \_\_\_\_\_

NAME \_\_\_\_\_

(last) (first) (middle)

ADDRESS \_\_\_\_\_

(city) (state) (zip code)

TELEPHONE \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ SS# \_\_\_\_\_

D.O.B. \_\_\_\_\_

PARENT'S NAME IF MINOR \_\_\_\_\_

PATIENT'S OCCUPATION \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_

(address)

(telephone) (ext.)

SPOUSE'S OCCUPATION \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_

(address)

(telephone) (ext.)

**MEDICAL INSURANCE**

PRIMARY: Name of Company \_\_\_\_\_

Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Group # \_\_\_\_\_

Policy # \_\_\_\_\_ D.O.B. \_\_\_\_\_

SECONDARY: Name of Company \_\_\_\_\_

Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ SNN \_\_\_\_\_

Policy # \_\_\_\_\_ D.O.B. \_\_\_\_\_

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**RELATIVE NOT LIVING IN YOUR HOME WHOM WE MAY CONTACT IN CASE OF EMERGENCY**

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

(last) (first) (middle)

ADDRESS \_\_\_\_\_

(number & street) (P.O. Box) (city) (state) (zip code)

**-OVER-**

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Name:

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DOB:

Date:

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I INTEND TO PAY MY MEDICAL EXPENSES AS FOLLOWS: (Check one or more)

Cash/Check

Master Card/Visa

Medicare

PPO/HMO Insurance

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**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**

I authorize treatment of the person named above and agree to pay all fees charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to billing date.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereof, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for collection.

**ASSIGNMENT OF BENEFITS**

I hereby authorize Obstetrics and Gynecology Associates, P.A., to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such surgical or medical care.

I also authorize and request my insurance company to pay directly to the above named Doctors the amount due me in my claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or services rendered to:

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(Please print patient's name)

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(Signature)

Name:  
DOB:

Referred by:  
Date:

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**Obstetrics & Gynecology Associates, P.A.**

**407-846-7200**  
**Fax: 407-845-3989**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated: \_\_\_\_\_

Patient or Patient's Representative: \_\_\_\_\_

Print Patient's Name: \_\_\_\_\_

If signed by Representative, state name of Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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