Contemporary Obstetrics & Gynecology

PATIENT REGISTRATION

Name:_____ Birth Date:_____ SS#_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Patient's Employer:_____ Referred by:_____

Primary Care Physician:_____ City:_____

Marital Status: S M D W Separated Student Status: Full Time Part Time

Pharmacy:_____ Location:_____

Emergency Contact: _____ Phone:_____

Spouse/Nearest Relative: _____ Phone:_____

INSURANCE INFORMATION

Primary Insurance:_____ Insured:_____

Policy #:_____ Group#_____ Effective Date:_____

Insured's SS#:_____ DOB:_____ Employer:_____

Secondary Insurance:_____ Insured:_____

Policy#:_____ Group#:_____ Effective Date:_____

Insured's SS#:_____ DOB:_____ Employer:_____

I hereby authorize the office of Contemporary Obstetrics & Gynecology to furnish information to insurance carriers including periodic quality assurance checks, and I hereby assign payment for medical services provided to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature:_____ Date:_____

PATIENT PERSONAL HEALTH HISTORY
NEW EXAM FORM

Name: _____DOB: _____ Age: _____

Last Menstrual Period: _____ Primary Care Dr.: _____

Employer: _____ Occupation: _____

HEALTH CARE PROVIDERS
List any health care providers from whom you are currently receiving treatment of any kind:

Provider: _____ Specialty: _____

Address: _____ Phone# _____

Provider: _____ Specialty: _____

Address: _____ Phone# _____

Provider: _____ Specialty: _____

Address: _____ Phone# _____

CURRENT MEDICATIONS
Please list all medications you are currently taking, including aspirin, pain relievers, vitamins, herbal supplements, etc…

Medication	Dosage	Frequency	Prescribing Doctor

ALLERGIES

Medication/Substances	Reaction

LIFESTYLE FACTORS

Do you smoke?	□Yes □No	Packs per day _____ Years _____
Did you use to smoke?	□Yes □No	Packs per day _____ Years _____
Do you use alcohol?	□Yes □No	Drinks per day _____ Per week _____
Do you use illegal drugs	□Yes □No	Type _____
Do you exercise regularly?	□Yes □No	Type _____
Do you wear a seatbelt?	□Yes □No	
Do you have a Living Will?	□Yes □No	Do you have a Health Care Proxy? □Yes □No

REVIEW OF SYSTEMS **Name: _____**

Please check the box if you are experiencing or have experienced any of the following symptoms

Constitutional
- Fatigue □
- Fever □
- Weight gain □
- Weight loss □

EYES
- Spots before eyes □
- Double vision □
- Visual changes □

ENMT
- Earaches □
- Ringing in ears □
- Sinus problems □
- Dental problems □
- Mouth or Tongue sores/lesions □
- Sore throat □

Cardiovascular
- Painful breathing □
- Chest pain □
- Difficulty breathing on exertion □
- Palpitations □
- Swelling of legs □

Respiratory
- Cough, chronic □
- Spitting up blood □
- Shortness of breath □
- Wheezing □

Gastrointestinal
- Bloody stools □
- Constipation □
- Diarrhea, frequent □
- Nausea □
- Vomiting □

Musculoskeletal
- Muscle weakness □

Genitourinary
- Pain with periods □
- Painful intercourse □
- Heavy menstrual bleeding □
- Blood in urine □
- Frequent urination □
- Pain with urination □
- Urgency □
- Leakage of urine □

Skin/Breast
- Breast discharge □
- Mass in breast □
- Pain in breast □
- Rashes □
- Ulcers □

Neurological
- Trouble walking □
- Dizziness □
- Numbness □
- Seizures □

Psychiatric
- Anxiety □
- Crying**,** frequent □
- Depression □

Endocrine
- Dry skin □
- Excessive thirst □
- Hot flashes □

Hemotological/Lymphatic
- Bruises, frequent □
- Prolonged bleeding □
- Enlarged lymph nodes □

IMMUNIZATIONS

Please check the box of the shots you have received and the date (if known)

Chicken Pox	□	_____	Pneumonia	□	_____
Hepatitis B	□	_____	TB Skin Test	□	_____
Flu shot	□	_____	MMR	□	_____
Tetanus	□	_____			

PERSONAL MEDICAL HISTORY **Name: _____**

Please check the box if you are experiencing or have experienced any of the following symptoms

Allergies	□	High cholesterol	□
Anemia	□	Kidney infection/stones	□
Anesthesia problems	□	Mitral valve prolapse	□
Arthritis/joint pain	□	Osteoporosis	□
Asthma	□	Pneumonia	□
Bowel trouble	□	Reflux	□
Cancer	□	Rheumatic fever	□
Chicken Pox	□	Psychiatric disorder	□
Chronic lung disease	□	Seizures/epilepsy	□
Depression/anxiety	□	Shingles	□
Diabetes	□	Stomach problems	□
Endometriosis	□	Stroke	□
Fractures	□	Thyroid disease	□
Glaucoma	□	Tuberculosis	□
Heart disease	□	Ulcers/GERD	□
Hepatitis/jaundice	□	Uterine fibroid	□
High blood pressure	□	Varicose veins	□

Do you have any medical condition not noted above: _____

Have you ever had a blood transfusion: YES NO If Yes, when: _____

Reason for Transfusion: _____

FAMILY HISTORY

Please check the box if a family member has a history of the following illnesses

		Relative			Relative
Alcohol/drug abuse	□	_____			
Anesthesia problems	□	_____	High Blood Pressure	□	_____
Blood clots	□	_____	Osteoporosis	□	_____
Breast cancer	□	_____	Ovarian Cancer	□	_____
Colon cancer	□	_____	Prostate Cancer	□	_____
Depression/anxiety	□	_____	Stroke	□	_____
Diabetes	□	_____	Thyroid disease	□	_____
Heart disease	□	_____	Uterine cancer	□	_____

Is there other family history of illness not listed above? _____

Comments: _____

_____

GYNECOLOGIC HISTORY **Name: _____**

Please complete blanks and/or circle the appropriate answers

Menstrual History

Date of last menstrual period _____ Age of first period _____

How often do you get your period _____ Number of days it lasts _____

Flow: heavy moderate light Cramps: YES NO Sometimes

Spotting Between Periods: YES NO Sometimes

Date of Last Mammogram _____ Facility _____

Date of Last Pap Smear _____ Facility _____

Have you ever had an Abnormal Pap: YES NO Treatment _____

Have you ever had a bone density (DEXA) test: YES NO Facility _____

Sexual History

Are you currently Sexually Active: YES NO Age of first coitus: _____

Type of Contraception (birth control): _____

Number of lifetime partners: _____ Date last tested for HIV: _____

History of STD (sexually transmitted disease; GC, Chlamydia, HPV, HSV): YES NO

Do you have pain or problems with intercourse: YES NO

SURGICAL HISTORY

List details of past surgical procedures in the table below:

Operation	Date	Hospital	Surgeon

OBSTETRIC HISTORY **Name: _____**

How many times have you been pregnant: _____

Please complete this table only if you are **PAST child bearing years**

Birth Date (month, year)	Outcome - live birth, miscarriage, still birth, termination	Sex M/F	Delivery Type - vaginal, cesarean, forcept	Hospital	Child's Name

Please complete this table only if you are still **IN child bearing years**

Birth Date month, year	Outcome - Live birth, miscarriage, still birth, termination	# of weeks pregnant	Length of Labor	Sex M/F	Birth Weight	Delivery type – vaginal, cesarean, forceps	Epidural Y/N	Hospital	Pre-term labor Y/N	Complications Y/N	Child's Name

Do you currently have any problems or concerns you would like to discuss with the provider?

_____

_____

Patient Signature: _____ Date: _____

CONTEMPORARY OBSTETRICS & GYNECOLOGY
132 NORTH ST
AUBURN, N.Y. 13021

PATIENT HIPPA INFORMATION FORM

Please complete this section for your file:

NAME: _____

ADDRESS: _____

HOME: _____ CELL: _____ WORK_____

EMAIL: _____

PHARMACY:_____ ADDRESS: _____

May we leave Medical Information or Appointment Reminders on:

Cell Phone	Yes	No
Home Phone	Yes	No
Work Phone	Yes	No

Preferred Phone Number: _____

Other Person or Persons authorized to communicate with:

NAME: _____RELATIONSHIP: _____

NAME: _____RELATIONSHIP: _____

Acknowledgement of Receipt of Notice of Privacy Practices

This notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act. By signing below, you acknowledge that you have read this notice and understand that you may receive a copy of the policy in its entirety upon request.

X _____ _____

Patient Signature Date

_____

Printed Name