***WELCOME TO OUR OFFICE***

*Please Complete this form and return it to the receptionist. PLEASE PRINT.*

PATIENT NAME_____ DATE OF BIRTH _____

MAILING ADDRESS _____

CITY_____ STATE ____ ZIP _____ PHONE _____

SOCIAL SECURITY # _____ MARITAL STATUS _____

PATIENT'S EMPLOYER _____WORK PHONE _____

OCCUPATION _____ CELL PHONE_____

**IN CASE OF EMERGENCY PLEASE NOTIFY:**

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____ WORK PHONE _____

**** IF MARRIED, PLEASE INDICATE SPOUSE'S NAME AND DAYTIME PHONE*****

**RESPONSIBLE PARTY (IF PATIENT IS A MINOR)**

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE ___ ZIP _____

PHONE NUMBER _____ WORK PHONE _____

***INSURANCE INFORMATION***

PRIMARY INSURANCE CO. _____

POLICY NO._____ GROUP NO. _____ CONTRACT_____

POLICY HOLDER _____ POLICY HOLDER DOB _____

POLICY HOLDER'S EMPLOYER _____

SECONDARY INSURANCE CO. _____

POLICY NO. _____ GROUP NO. _____ CONTRACT _____

POLICY HOLDER _____ POLICY HOLDER DOB _____

POLICY HOLDER'S EMPLOYER _____

_____ _____

DATE SIGNATURE

## RELEASE OF INFORMATION

I HERBY AUTHORIZE AND ALLOW BROOME OBSTETRICS AND GYNECOLOGY, PC HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, HOSPITALS, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE, ALL INFORMATION NEEDED FOR MEDICAL TREATMENT, HEALTHCARE OPERATIONS AND TO SUBSTANTIATE PAYMENT FOR SUCH MEDICAL CARE TO PERMIT REPRESENTATIVE THEREOF TO EXAMINNE AND MAKE COPIES OF ALL RECORDS, INCLUDING HIV, RELATING TO SUCH CARE AND TREATMENT.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

## INSURANCE ASSIGNMENT

I HERBY ASSIGN, TRANSFER AND SET OVER TO BROOME OBSTETRICS AND GYNECOLOGY PC SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN SAID MEDICAL GROUP.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

## PRIVACY RELEASE

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF BROOME OBSTETRICS AND GYNECOLOGY, PC.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

## MEDICARE RELEASE

I CERTIFY THAT THE INFORMATION GIVEN TO ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR ITS CARRIERS, ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS. I REQUEST PAYMENT TO BE MADE TO BROOME OBSTETRICS AND GYNECOLOGY, PC.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

## PAYMENT AND/OR CO-PAYS ARE DUE AT THE TIME OF SERVICE

Patient Name _____ DOB_____

## FAMILY HISTORY

| Illness | Relative | Age onset | Illness | Relative | Age onset |
|---|---|---|---|---|---|
| Y N Breast Cancer | | | Y N Ovarian Cancer | | |
| Y N Colon Cancer | | | Y N Other Cancer | | |
| Y N Heart Disease | | | Y N Hypertension | | |
| Y N Depression/Anxiety | | | Y N Stroke | | |
| Y N Thyroid Disease | | | Y N Osteoporosis | | |
| Y N Bleeding Disorders | | | Y N Mental Retardation | | |
| Y N Birth Defects | | | Y N Genetic Disease | | |
| Y N Diabetes | | | Y N Other | | |

## SOCIAL HISTORY

Tobacco Use Y N How Much_____ Number of Years_____
Alcohol Use Y N How Much_____
Recreational Drug Use Y N How Much_____ Number of Years_____
Calcium Intake Y N Calcium Supplement Y N _____
Caffeine Intake Y N How Much_____
Exercise Y N How often_____ Type_____

## MEDICATIONS (INCLUDING OVER THE COUNTER)

| Medication | Medication | Medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

See Attached List _____

## MENSTRUAL HISTORY

Age at first menstrual period _____
Cycle length_____ Flow length_____
Menstrual flow – Light_____ Moderate_____ Heavy _____

If you have stopped having menstrual periods, at what age did you have your last one _____

Date Updated and Reviewed

_____ _____ _____ _____ _____ _____ _____

**BROOME OBSTETRICS AND GYNECOLOGY, P.C.**

Patient Name _____ Date _____
Date of Birth _____ Primary Care Physician _____
Referred By _____ Physician Address _____
Specialists _____

**ALLERGIES (REACTIONS)** _____ (_____) _____ (_____)
_____ (_____) _____ (_____) _____ (_____)

**PERSONAL MEDICAL HISTORY:**

| | | | | | |
|---|---|---|---|---|---|
| Y N | Heart Disease | Y N | Hypertension | Y N | High Cholesterol |
| Y N | Stroke | Y N | Bleeding Disorders | Y N | Mitral Valve Prolapse |
| Y N | Asthma | Y N | Thyroid Disease | Y N | HIV |
| Y N | Osteopenia | Y N | Osteoporosis | Y N | Joint Replacement |
| Y N | Diabetes | Y N | Anxiety | Y N | Depression |
| Y N | GERD | Y N | Peptic Ulcer Disease | Y N | Migraines |
| Y N | Cancer | Y N | Seizures | Y N | STD Exposure |

Other _____

**GENETIC TESTING:**

Y N BRCA Who was tested _____ Discussed _____
Results _____

Y N Multi-Gene Who was tested _____ Discussed _____
Results _____

**FAMILY PLANNING:** _____

**OPERATIONS/HOSPITALIZATIONS:**

| Date | Procedure | Physician |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**OBSTETRICAL HISTORY:**

| Date | Type of Delivery (Complications) | Physician |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

DEXA scan Y N Date/Where _____ _____ _____
Colonoscopy Y N Date/Where _____ _____ _____
Gardasil Vaccine Y N Date/Where _____ _____ _____

Date Updated and Reviewed

_____ _____ _____ _____ _____ _____ _____

Name:_____ Date:_____ Medical Doctor: _____

Last menstrual period: _____ Medications: _____

Please check any of the following symptoms that apply to you. Thank You.

| **CONSTITUTIONAL** | **YES** | **NO** |
|---|---|---|
| Weight loss | ___ | ___ |
| Weight gain | ___ | ___ |
| Change in height | ___ | ___ |
| Fever | ___ | ___ |
| **EYES/EARS/NOSE/THROAT** | | |
| Vision changes | ___ | ___ |
| Earaches | ___ | ___ |
| Hearing problems | ___ | ___ |
| Sore throat | ___ | ___ |
| Mouth sores | ___ | ___ |
| **CARDIOVASCULAR** | | |
| Chest pain | ___ | ___ |
| Swelling of legs | ___ | ___ |
| Rapid/irregular heartbeat | ___ | ___ |
| **RESPIRATORY** | | |
| Coughing up blood | ___ | ___ |
| Shortness of breath | ___ | ___ |
| Chronic cough | ___ | ___ |
| Wheezing | ___ | ___ |
| **GASTROINTESTINAL** | | |
| Frequent diarrhea | ___ | ___ |
| Bloody stool | ___ | ___ |
| Nausea/vomiting | ___ | ___ |
| Constipation | ___ | ___ |
| Change in bowel habits | ___ | ___ |
| Abdominal bloating | ___ | ___ |
| Frequent indigestion | ___ | ___ |
| Hemorrhoidal pain | ___ | ___ |
| **URINARY** | | |
| Blood in urine | ___ | ___ |
| Pain with urination | ___ | ___ |
| Strong urgency to urinate | ___ | ___ |
| Frequent urination | ___ | ___ |
| Incomplete emptying | ___ | ___ |
| Involuntary urine loss | ___ | ___ |
| Urine loss w/cough/lift | ___ | ___ |
| **GYNECOLOGICAL** | | |
| Abnormal bleeding | ___ | ___ |
| Painful periods | ___ | ___ |
| Painful intercourse | ___ | ___ |
| Abnormal vaginal discharge | ___ | ___ |
| Itching | ___ | ___ |
| Possible contact with sexually transmitted disease | ___ | ___ |
| Bleeding with intercourse | ___ | ___ |

| **MUSCULOSKELETAL** | **YES** | **NO** |
|---|---|---|
| Muscle weakness | ___ | ___ |
| Muscle/joint pain | ___ | ___ |
| **SKIN** | | |
| Bruises | ___ | ___ |
| Rash | ___ | ___ |
| Changes in moles | ___ | ___ |
| **BREASTS** | | |
| Pain in breasts | ___ | ___ |
| Nipple discharge | ___ | ___ |
| Lumps | ___ | ___ |
| **NEUROLOGIC** | | |
| Seizures | ___ | ___ |
| Dizziness | ___ | ___ |
| Numbness | ___ | ___ |
| Frequent/severe headaches | ___ | ___ |
| **PSYCHIATRIC** | | |
| Feeling down/sad | ___ | ___ |
| Feeling anxious | ___ | ___ |
| **ENDOCRINE** | | |
| Heat/cold intolerance | ___ | ___ |
| Abnormal thirst | ___ | ___ |
| Hot flashes | ___ | ___ |
| Chronic fatigue | ___ | ___ |
| **HEMATOLOGIC/LYMPHATIC** | | |
| Cuts that do not stop bleeding | ___ | ___ |
| Enlarged lymph nodes/glands | ___ | ___ |
| **ALLERGIC/IMMUNOLOGIC** | | |
| Medication allergies? | ___ | ___ |
| List:_____ | | |
| Other allergies? | ___ | ___ |
| List:_____ | | |
| Do you drink alcohol? | ___ | ___ |
| How much?_____ | | |
| Do you smoke? | ___ | ___ |
| How much?_____ | | |
| Do you exercise? | ___ | ___ |
| Would you like information on domestic violence? | ___ | ___ |

## First Prenatal/Pregnancy Visit

## Health History

Please fill this in to the best of your ability and bring it with you to your first prenatal (pregnancy) visit.

**Do you or does anyone in your immediate blood-related family (mother, father, brothers, sisters, aunts, uncles, grandparents) have any history of:**

(if any answer is yes, please specify who has/had the problem and any details you're aware of)

1. Birth defects_____
2. Genetic diseases _____
3. Multiple births_____
4. Diabetes_____
5. Cancer_____
6. High blood pressure_____
7. Heart disease _____
8. Rheumatic fever _____
9. Pulmonary (lung) disease_____
10. GI (stomach/intestines) problems_____
11. Renal (kidney) disease_____
12. Genitourinary tract problems_____
13. Abnormal uterine bleeding_____
14. Infertility_____
15. Sexually transmitted infection_____
16. Phlebitis, varicose veins, blood clots_____
17. Neurological (brain/nerves/spinal cord) problems_____
18. Metabolic/Endocrine problems (e.g. thyroid problems) _____
19. Anemia/Hemoglobinopathies_____
20. Blood disorders_____
21. Drug abuse_____
22. Smoking or Alcohol use_____
23. Infectious diseases_____
24. Operations/accidents_____
25. Allergies or medication sensitivities_____
26. Blood transfusion_____
27. Other hospitalizations_____
28. Have you ever had chicken pox?

    _____
29. Have you ever had mononucleosis (mono)?

    _____
30. Have you ever had herpes?

    _____

For your previous births (if any), please complete the following:

| Month/ year | Sex | Weight | Weeks gestation | # Hrs labor | Type of delivery | Complications/Anesthesia used? | Name of child |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

We will also be giving you the orders to have your blood drawn for your initial prenatal screening at your first pregnancy visit. You will need to take these forms to the registration area in the main entrance to the hospital where they will register you and send you to the lab for the blood to be drawn. You may have these done any time the lab is open. These tests include the following:

Complete blood count - baseline level of your iron stores and clotting ability (platelets)

Blood type and Rh – Rh negative requires assessment for the need for Rhogam

Antibody – tells us if you have certain antibodies in your blood that could require further testing

Serology (RPR) – a screening test for syphilis

Rubella titer – immunity to the rubella virus

Urinalysis and urine culture – bladder infection or kidney problems

Blood sugar – higher sugar levels could require more testing to rule out diabetes

Hepatitis B surface antigen –Hepatitis B virus

Your individual provider may also check other labs per their preference based on your individual needs.