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)_____ (_____)
_____ (_____) _____ (_____)

MEDICAL HISTORY

Y N Heart Disease_____
Y N Stroke_____
Y N Asthma_____
Y N Osteopenia_____
Y N Diabetes_____
Y N GERD_____
Y N Cancer_____

Y N Hypertension_____
Y N Bleeding Disorders_____
Y N Thyroid Disease_____
Y N Osteoporosis_____
Y N Anxiety/Depression_____
Y N Peptic Ulcer Disease_____
Y N Seizures_____

Y N High Cholesterol_____
Y N Mitral Valve Prolapse_____
Y N HIV_____
Y N Joint Replacement_____
Y N Migraines_____
Y N Transfusion HX_____
Y N STD Exposure_____

Other_____

FAMILY PLANNING_____

OPERATIONS/HOSPITALIZATIONS

Date	Procedure	Physician

OBSTETRICAL HISTORY G____ T____ Pt____ A____ L____

Date	Type of Delivery (Complications)	Physician

DEXA Scan Y N Date's_____ _____ _____
Colonoscopy Y N Date's_____
Gardasil Vaccine's Y N Date's_____ _____ _____

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.