

PATIENT INFORMATION

Today's Date: _____

(Please Print Clearly)

Name: (First, Middle Initial, Last) _____

Address: _____

Street, Apt # _____ City _____ State _____ Zip _____

Home Phone Number: _____ Cell Number: _____

Emergency Number: _____ Driver's License #: _____

SS#: _____ DOB: _____ Age: _____ Race: _____

Marital Status: _____ Religion: _____

Name of your Primary Care Physician _____ Phone Number: _____

PATIENT'S EMPLOYMENT

E-Mail Address: _____

May we send you emails/information about our services? Yes *circle* No

Employed By: _____ Occupation: _____

Address: _____ Business Phone: _____

Street _____ City _____ State _____ Zip _____ x _____

SPOUSE'S INFORMATION

Spouse's Name: _____ SS#: _____ DOB: _____

Spouse's Employer: _____ Business Phone: _____

Employer's Address: _____

Street _____ City _____ State _____ Zip _____

Who Referred You To This Office: _____

(This reference is for office use only)

MEDICAL INSURANCE INFORMATION

Please give your card to receptionist for photocopy and/or insurance form if applicable

INSURANCE INFORMATION

Insurance Company Name or Hub (IPA): _____ Phone: _____

Group Number: _____ Policy Number: _____ Effective date: _____

Policy Holder's Name: _____ DOB: _____

Secondary Insurance Name: _____ Phone: _____

Group Number: _____ Policy Number: _____ Effective date: _____

RESPONSIBLE PARTY

Please complete the following if someone other than you the patient or your spouse is responsible for this bill, example: Child, Dependent -

Guarantor's Name: _____ Relationship to the Patient: _____

Address of Guarantor: _____ DOB: _____

Street _____ City _____ State _____ Zip _____

Home Phone Number: _____ Business Phone Number: _____

Employed By: _____

Signature of Guarantor of Payment: _____ Date: _____

RECORD OF PERSONAL HISTORY

Today's Date

NAME: _____ AGE: _____ DOB: _____
Are you here for a routine check up? Yes No If you have any medical problems at this time please state: _____

PAST HISTORY

Have you ever had any operations such as tonsillectomy, hysterectomy, etc., ? List WHEN, WHERE, & WHAT Type of Surgery:

MEDICAL HISTORY

Mark an "X" in the Appropriate Response

| | YES | NO | | YES | NO |
|-----------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| DES Child | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | | |

Explanation of above: _____

SKIN

(Circle Y=Yes N=No)

Prolonged bleeding from cuts? Y N
Blood clots in legs? Y N

EYES

Wear glasses or contact lenses? Y N

EARS

Difficulty in Hearing? Y N
Ringing in the Ears? Y N
Frequent Dizzy Spells? Y N

NOSE, MOUTH, THROAT

Frequent Nose Bleeds? Y N
Wear Dentures? Y N
Frequent Sore Throats? Y N
Hay fever or Allergies? Y N

CHEST

Ever had high blood pressure? Y N
Heart trouble, murmur, or pain? Y N
Sever shortness of breath? Y N
Chronic cough? Y N
Ever cough up blood? Y N
Ankle swelling? Y N
Heart often skips a beat or race? Y N

GASTROINTESTINAL

Chronic Constipation or Diarrhea? Y N
Recent Change in Bowel Habits? Y N
Bloody or Tarry stools? Y N
Gallbladder disease, ulcer, jaundice, colitis? Y N

URINARY TRACT

Ever had Kidney or Bladder Infections? Y N
NOW have pain, urgency or burning with Urination? Y N
Ever passed blood in your urine? Y N

NEUROMUSCULAR

Ever had a convulsion? Y N
Ever had swollen, red or stiff joints? Y N
Have paralysis or deformity? Y N

ENDOCRINE

Any Thyroid problems? Y N
Ever been told you are diabetic? Y N
Has your weight varied over 10 pounds in the last year? Y N

FAMILY HISTORY

List Disease and how it relates to you – Name: _____
Cancer, Diabetes, Heart Disease, Stroke, Other Major History: _____

SOCIAL HISTORY

Marital Status: _____ How Many Years? _____
If Divorced, how long? _____

Is your marriage satisfactory? _____ Do you Drink? _____ How Much? _____
Are you usually depressed lately? _____ Do you smoke? _____ How Much? _____
Are you presently taking recreational drugs, marijuana, cocaine, etc? _____

GYNECOLOGICAL & OBSTETRICAL HISTORY

Date of Last Pap? _____

Date of last Menstrual Period? _____ Was it Normal? _____ Days Flow? _____
Number of Days Between Periods? _____ At What age did you begin your Period? _____
How many pads/tampons per day at the beginning of your Period? _____ & at the End? _____

What type of Birth Control are you now using? (Please Circle) None IUD Diaphragm Tubal ligation
Vasectomy Pill (which one?) _____ or Other Method: _____

(Circle Y=Yes N=No for the following questions)

| | | | | | |
|-----------------------------------|---|---|---|---|---|
| Are your periods irregular? | Y | N | Have you ever had a Pelvic Infection? | Y | N |
| Pain with or prior to Periods? | Y | N | Have you past Menopause? | Y | N |
| Clots with Periods? | Y | N | If the above is Yes: | | |
| Any bleeding between Periods? | Y | N | Have you had any bleeding? | Y | N |
| Any bleeding during or after sex? | Y | N | Any "Hot Flashes" | Y | N |
| Any pain with sex? | Y | N | Do you take hormones? | Y | N |
| Medication for pain with periods? | Y | N | Have you noticed any lumps or discharge | | |
| Any Abnormal vaginal discharge? | Y | N | From breasts or nipples? | Y | N |
| Ever had a Venereal Disease? | Y | N | Do you lose urine when you cough or | | |
| Ever had German Measles? | Y | N | Sneeze? | Y | N |

PREGNANCIES

How many Pregnancies? _____ How many Living Children? _____
Age at First Pregnancy? _____

How many Miscarriages or Abortions? _____ Any Premature Babies? _____

List in order all your Pregnancies or use separate sheet if nessary:

Date Sex Weight Any Complications List- Cesarean Sections, Breech, Etc.

DRUGS RECENTLY TAKEN

Pharmacy Name, address & phone – Attach additional sheet - _____

ALLERGIES & SENSITIVITIES

Allergies & Sensitivities: _____

MAIL FORM TO: Suburban Women's Health Specialists, LTD., 2350 Royal Blvd., #600, Elgin IL 60123
OR FAX TO: 847.622.3998 At least 72 hrs prior to your scheduled appointment.