PATIENT INFORMATION SHEET

Date:________________
MM/DD/YY

First Name:______________________ Middle Initial:________ Last Name:______________________

Address:______________________ City:________________ State:______ Zip Code:__________

Home Phone:______________________ Cell:________________ Work:________________

Date of Birth (MM/DD/YY):________________ SSN:________________ Driver's License:________________

Primary Care Physician:________________ Phone Number:________________ Religion:________________

Referred by:______________________________ Email Address:______________________________

NOTIFICATION CONSENT: It is the policy of our office to call you with the laboratory, pap smears, ultrasound, mammograms, or existing office visit. If you have not heard from us in 21 days of having the testing completed, please call our office.

We may communicate your medical information with: ❑ Patient Only ❑ Spouse ❑ Parent ❑ Answering Machine ❑ All

PREFERRED METHOD OF COMMUNICATION:
❑ Home Phone ❑ Cell
❑ Email ❑ Other:____________

MARITAL STATUS:
❑ Single ❑ Married ❑ Divorced
❑ Separated ❑ Widowed

EMPLOYMENT STATUS:
❑ Full-time ❑ Part-time ❑ Retired
❑ Other ❑ N/A

SPOUSE'S INFORMATION:

Spouse's Name:______________________ SSN:________________ DOB:________________

Spouse's Employer:______________________________ Business Phone:______________________________

Business Address:______________________ City:________________ State:______ Zip Code:__________

INSURANCE INFORMATION:

Insurance Company Name or HMO (IPA):______________________________ Phone:________________

Group Number:______________________ Policy Number:________________ Effective Date:________________

Policy Holder's Name:______________________________ DOB:________________

Secondary Insurance Name:______________________________ Phone:________________

Group Number:______________________ Policy Number:________________ Effective Date:________________

Policy Holder's Name:______________________________ DOB:________________

If minor, who is responsible party?______________________________

EMERGENCY CONTACT:

Name:______________________ Phone Number:________________ Relationship:________________

Do we have permission to contact this person regarding matters concerning your care? ❑ Yes ❑ No

ETHNICITY: (check one)
❑ Non-Hispanic
❑ Hispanic
❑ Refused to Report

PRIMARY RACE: (check one)
❑ White
❑ Hispanic
❑ African American/Black
❑ Asian
❑ Native American
❑ Native Hawaiian
❑ Other Pacific Islander
❑ Other Race
❑ Unreported/Refused

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Other Interpreter Needed? ❑ Yes ❑ No

PREFERRED PHARMACY# 1:______________________________

Address:______________________________ Phone Number:________________ Mail Order? ❑ Yes ❑ No

PREFERRED PHARMACY# 2:______________________________

Address:______________________________ Phone Number:________________ Mail Order? ❑ Yes ❑ No

ELECTRONIC PRESCRIPTIONS: Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

❑ I would like to receive information about current products and procedures available through your Medical Spa.

It is my responsibility to notify the office if changes are made to any of the above information.

Patient or Guardian Signature:______________________ Relationship to Patient:__________ Date:__________

Patient Name:________________________ DOB:__________ Age:______ Date:__________

MM/DD/YY MM/DD/YY

RECORD OF PERSONAL HISTORY

Are you here for a routine check up? ❑ Yes ❑ No

If you have any medical problems at this time, please state below:

PAST HISTORY	
	Yes/No
Have you ever had any operations such as tonsillectomy, hysterectomy, etc.? If YES, list WHEN, WHERE, and WHAT type of surgery.	

MEDICAL HISTORY	
	Yes/No
Asthma	
Cancer	
DES child	
Diabetes	
Heart attack	
Hepatitis	
High blood pressure	
Other (please explain):	

SKIN	
	Yes/No
Prolonged bleeding from cuts?	
Blood clots in legs?	

EYES	
	Yes/No
Wear glasses or contact lenses?	

EARS	
	Yes/No
Difficulty in hearing?	
Ringing in the ears?	
Frequent dizzy spells?	

NOSE, MOUTH, THROAT	
	Yes/No
Frequent nose bleeds?	
Wear dentures?	
Frequent sore throats?	
Hay fever or allergies?	

CHEST	
	Yes/No
Ever had high blood pressure?	
Heart trouble, murmur, or pain?	
Severe shortness of breath?	
Chronic cough?	
Ever cough up blood?	
Ankle swelling?	
Heart often skips a beat or races?	

GASTROINTESTINAL	
	Yes/No
Chronic constipation or diarrhea?	
Recent change in bowel habits?	
Bloody or tarry stools?	
Gallbladder disease, ulcer, jaundice, colitis?	

URINARY TRACT	
	Yes/No
Ever had kidney or bladder infections?	
NOW have pain, urgency or burning with urination	
Ever passed blood in your urine?	

NEUROMUSCULAR	
	Yes/No
Ever had a convulsion?	
Ever had swollen, red or stiff joints?	
Have paralysis or deformity?	

ENDOCRINE	
	Yes/No
Any thyroid problems?	
Ever been told you are diabetic?	
Has your weight varied over 10 pounds in the last year?	

Patient Name:________________________ DOB:__________ Age:______ Date:__________
MM/DD/YY MM/DD/YY

FAMILY HISTORY

List disease and how it relates to you (cancer, diabetes, heart disease, stroke, other major history):

SOCIAL HISTORY

Marital status:		Do you drink?		Do you smoke?	
Number of years married:		How much?		How much?	
Is your marriage satisfactory?		Are you usually depressed lately?		Are you presently taking recreational drugs?marijuana, cocaine, etc.?	
If divorced, how long?					

GYNECOLOGICAL & OBSTETRICAL HISTORY

Date of last pap:		Number of days between periods:	
Date of last menstrual period:		Age of first period:	
Was it normal?		Number of pads/tampons per day at beginning of period:	
Number of days flow:		Number of pads/tampons per day at end of period:	

What type of birth control are you currently using?

❏ None ❏ IUD ❏ Diaphragm ❏ Tubal Ligation ❏ Vasectomy ❏ Pill (which one?) __________ ❏ Other Method __________

	Yes/No
Are your periods irregular?	
Pain with or prior to periods?	
Clots with periods?	
Any bleeding between periods?	
Any bleeding during or after sex?	
Any pain with sex?	
Medication for pain with periods?	
Any abnormal vaginal discharge?	
Ever had a venerial disease?	

	Yes/No
Ever had German measles?	
Have you ever had a pelvic infection?	
Have you past menopause?	
If the above is YES:	
Have you had any bleeding?	
Any hot flashes?	
Do you take hormones?	
Noticed any lumps or discharge from breasts or nipples?	
Do you lose urine when you cough or sneeze?	

How many pregnancies?__________ Age at first pregnancy?__________ How many living children?__________

LIST ALL PAST PREGNANCIES - INCLUDING: MISCARRIAGES, ABORTIONS, ECTOPICS, STILLBORNS

Date mm/dd/yy	Birth Weight	Sex	Type of Delivery	Comments/Complications

Drugs Recently Taken:______________________________

Pharmacy:__________ Address:__________ Phone Number:__________

Allergies and Sensitivities:______________________________

PLEASE COMPLETE AND RETURN FORM. **Email:** swhs2350@gmail.com **Fax:** 847-931-9602 **Mail:** Suburban Women's Health Specialists
2350 Royal Boulevard, #600
Elgin, IL 60123