WOMEN'S MEDICAL CENTER PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

DATE: _____

Patient Legal Name _____

If Minor, Parent or Legal Guardian Name _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Birth Date** _____

Cellular Phone _____ **Social Security #** _____

Message Phone _____ **Referred by** _____

Patient employed by _____ **Occupation** _____

Business Phone _____ **Are calls allowed?** ☐ **Yes** ☐ **No**

Emergency Contact (not at same number) _____ **Phone** _____

Marital Status ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Race ☐ **American Indian** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian** ☐ **White** ☐ **Other**

Ethnicity ☐ **Hispanic or Latino** ☐ **Non Hispanic or Latino** **Primary language** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: **Name of Insurance Company:** _____

Address of Insurance Company _____

Insurance Number _____ **Group #** _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ **Birth Date** _____ **Social Security #** _____

Employed by: _____ **Business Phone** _____

SECONDARY INSURANCE **Name of Insurance Company:** _____

Address of Insurance Company _____

Insurance Number _____ **Group #** _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ **Birth Date** _____ **Social Security #** _____

Employed by: _____ **Business Phone** _____

DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ Yes ☐ No

If no, would you like information on it? ☐ **Yes** ☐ **No**

AUTHORIZATION OF CARE

Authorization is given to Women's Medical Center, its providers and employees to provide services and administer provider orders. Certain procedures require a separate consent form.

_____ _____

Patient signature AND legal guardian signature (if patient is a minor) **Date**

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician/provider for services. Failure to pay any balance due by the undersigned may involve a collection agency or attorney. It is understood and agreed that reasonable attorney fees are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, agrees to pay all charges not paid in full to Women's Medical Center by a third-party payer.

_____ _____

Patient signature AND legal guardian signature (if patient is a minor) **Date**

WOMEN'S MEDICAL CENTER PRENATAL FORM

Please complete this form and return it IMMEDIATELY. This helps us get a lot of the paperwork done before you come in for your prenatal consult and cuts down on the time you have to wait. Thank you.

FOR OFFICE USE ONLY

APPOINTMENT

Date _____

Time _____

Day _____

SCHEDULED BY _____

PROOF OF PREGNANCY ☐ **Yes** ☐ **No**

+UPT at WMC ☐ **Yes** ☐ **No**

Name _____ **DOB** _____ **Social Security #** _____

Address _____ **City** _____ **State** _____

Phone Number (HOME) _____ (CELL) _____

1. First day of your last menstrual period? _____ Are you certain? ☐ YES ☐ NO
2. Is this a planned pregnancy? ☐ YES ☐ NO
3. Are you happy with the pregnancy? ☐ YES ☐ NO
4. Current HEIGHT _____ WEIGHT _____
5. Do you have any medication ALLERGIES? ☐ YES ☐ NO
   If yes, what are you allergic to and what happens? _____

SINCE YOUR LAST MENSTRUAL PERIOD

6. Have you had any vaginal bleeding or spotting? ☐ YES ☐ NO
   Did you have bleeding as much as a period? ☐ YES ☐ NO Spotting only? ☐ YES ☐ NO
   How often have you had the bleeding/spotting? _____
7. Have you had any nausea? ☐ Occasional ☐ Frequent ☐ None Vomiting? ☐ Occasional ☐ Frequent ☐ None
8. Have you had any breast tenderness? ☐ YES ☐ NO
9. Have you had any abdominal pain? ☐ YES ☐ NO
10. Have you had any vaginal discharge? ☐ YES ☐ NO
11. Have you had any headaches? ☐ YES ☐ NO
12. Have you had a fever above 101 degrees? ☐ YES ☐ NO
13. Have you had any illnesses? ☐ YES ☐ NO
14. Have you had any x-rays? ☐ YES ☐ NO
15. Have you taken any non prescription medications? ☐ YES ☐ NO If yes, please circle below:
    Tylenol Ibuprofen Aspirin Advil Sudafed NyQuil Tums Maalox Mylanta Pepto Bismal Other _____
16. Have you taken any prescription medications? ☐ YES ☐ NO If yes, list: _____

17. Are you?
    Please circle one: Married Single Widowed Divorced Separated In Relationship

18. **FATHER OF BABY**
    Name _____
    Race _____
    Age _____
    Occupation _____

19. **HAVE YOU EVER BEEN SEEN HERE?** ☐ YES ☐ NO
    If so, when? _____
    Have you ever been seen here using another name?
    ☐ YES ☐ NO
    If yes, what was the name? _____

20. Who do you live with? _____

Do you have any pets? ☐ YES ☐ NO If yes, what type? _____

21. Do you work outside the home? ☐ YES ☐ NO

If yes, do you work ☐ FULL TIME ☐ PART TIME

What type of work do you do? _____

22. What is your HIGHEST level of education? _____

23. What is your race? _____

24. Do you have any religious preference? _____

25. Do you exercise on a regular basis? ☐ YES ☐ NO What type of exercise? _____

26. Are you currently in a monogamous relationship? (only one sex partner) ☐ YES ☐ NO

Or do you have multiple sex partners? ☐ YES ☐ NO

27. Have you used any type of birth control in the past year? ☐ YES ☐ NO

Circle all that apply

Birth Control Pills When did you STOP taking them? _____

Depo Provera Shot When was your last Shot? _____

Condoms Other: IUD Nexplanon NuvaRing Dates removed: _____

28. Do you smoke? ☐ YES ☐ NO CURRENTLY how many per day? _____

FORMER date stopped _____ ☐ NEVER

Does anyone in the home smoke? ☐ YES ☐ NO If yes: ☐ Inside ☐ Outside

29. Do you drink alcohol CURRENTLY? ☐ YES ☐ NO FORMER date stopped _____ ☐ NEVER

30. Have you used any street drugs? ☐ YES ☐ NO

If yes, what type? _____ Date last used? _____

31. Do you wear your seat belt? ☐ ALWAYS ☐ OCCASIONALLY ☐ RARELY ☐ NEVER

32. Do you feel safe in your personal relationship? _____

FAMILY HISTORY check all that apply

MOTHER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

FATHER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

BROTHER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

SISTER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

AUNT

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

UNCLE

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

MATERNAL GRANDMOTHER (your mom's mom)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

MATERNAL GRANDFATHER (your mom's dad)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

PATERNAL GRANDMOTHER (your dad's mom)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

PATERNAL GRANDFATHER (your dad's dad)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

FAMILY HISTORY FOR YOU AND THE FATHER OF THE BABY

Genetic disorders ☐ YES ☐ NO If yes, who? _____ Type _____
Twins ☐ YES ☐ NO If yes, who? _____
Down Syndrome ☐ YES ☐ NO If yes, who? _____
Cystic Fibrosis ☐ YES ☐ NO If yes, who? _____
Blood disorders ☐ YES ☐ NO If yes, who? _____ Type _____
Neural Tube Defects ☐ YES ☐ NO If yes, who? _____
Tay-Sachs ☐ YES ☐ NO If yes, who? _____
Muscular Dystrophy ☐ YES ☐ NO If yes, who? _____
Seizure ☐ YES ☐ NO If yes, who? _____
3 or more miscarriages ☐ YES ☐ NO If yes, who? _____
Multiple Sclerosis ☐ YES ☐ NO If yes, who? _____
Stillborn babies ☐ YES ☐ NO If yes, who? _____

Other inherited genetic/chromosomal disorders ☐ YES ☐ NO If yes, who? _____

YOUR PAST MEDICAL HISTORY

Chemical abuse	☐ YES	☐ NO
Surgery	☐ YES	☐ NO
Trauma	☐ YES	☐ NO
Transfusion	☐ YES	☐ NO
Diabetes Mellitus	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
Thyroid disease	☐ YES	☐ NO
Cardiac disease	☐ YES	☐ NO
Multiple gestation	☐ YES	☐ NO
Gallbladder disease	☐ YES	☐ NO
Bleeding disorder	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
TB	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Renal disease	☐ YES	☐ NO
Recurrent UTI's (3 or more per year)	☐ YES	☐ NO
Migraines	☐ YES	☐ NO
Decreased Hearing	☐ YES	☐ NO
Decreased Vision	☐ YES	☐ NO
Hepatitis B	☐ YES	☐ NO
Colitis	☐ YES	☐ NO
Seizure disorder	☐ YES	☐ NO
Psychiatric disorder	☐ YES	☐ NO
Do you wear glasses or contacts?	☐ YES	☐ NO
STD	☐ YES	☐ NO

If yes, what type: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphillis ☐ Condyloma

What years were you treated? _____

SURGICAL HISTORY

List all surgeries and dates of surgery

_____

_____

PAST GYNECOLOGIC HISTORY

Age you had your first period _____

Are your periods regular? ☐ YES ☐ NO

How many days between periods? ☐ 21 days or less ☐ 28-31 days ☐ 35 days or more ☐ Other _____

How many days does each period last? _____

Is your flow ☐ LIGHT ☐ MODERATE ☐ HEAVY

GYN surgery? ☐ YES ☐ NO If yes, type and date _____

Abnormal PAP ☐ YES ☐ NO If yes, when? _____

When was your last PAP? _____

Uterine Anomaly ☐ YES ☐ NO

Infertility ☐ YES ☐ NO

PAST OBSTETRICAL HISTORY

How many pregnancies have you had? _____

How many full term deliveries? 37-40 weeks _____

How many pre-term deliveries? 21-36 weeks _____

How many miscarriages? Less than 20 weeks _____ Please list date and how many weeks below.

Have you ever had an ectopic (tubal) pregnancy? ☐ YES ☐ NO

How many pregnancy terminations? _____ Dates and gestational age _____

How many living children do you have? _____

SUMMARY OF PREGNANCIES, DELIVERIES, ABORTIONS, MISCARRIAGES

Date	**How many weeks**	**Length of Labor** (How many hours did you have pains?)	**Delivery: Vaginal or C-Section** (If vaginal, forceps or suction used?)	**Anesthetic** Epidural, IV med or put to sleep	**Sex of Baby**	**Baby's Birth weight**	**Complications** (Use space below if needed)	**City/State and Dr. Name** (City/State you delivered and Dr. who delivered baby)