Baldwin Woods OB/GYN

Women's Advanced Health & Wellness

Legal Name: _____ **SSN:** _____ **Date:** _____ **DOB:** _____

Home Address: _____
Address City ST Zip Code

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

E-mail address: _____ **Insurance Name:** _____

Employer Name: _____

Employer Address: _____
Address City ST Zip Code

Primary Care Provider: _____ **Referred by:** _____

Marital Status: Single Married Divorced Widowed

Spouse Name: _____ **SSN:** _____ **DOB:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Responsible Party if Different:

Name: _____ SSN: _____ DOB: _____

How old were you when you had your first menstrual period _____
How often do you menstrual cycles come _____
How many pad or tampons do you use daily _____
How long have you used birth control _____
Was your last cycle normal **Y N**

Are your cycles regular **Y N**
How many days do you bleed _____
Type of birth control _____
Last menstrual period _____
Was it painful **Y N**

Do you have any of the following?

Y or N	Fever or Chills	Y or N	Cough	Y or N	Back Pain
Y or N	Fatigue	Y or N	Shortness of Breath	Y or N	Nipple Discharge
Y or N	Headaches	Y or N	Nausea	Y or N	Bleeding Problems
Y or N	Weight Loss	Y or N	Vomiting	Y or N	Depression
Y or N	Changes in Vision	Y or N	Constipation	Y or N	Anxiety
Y or N	Sore Throat	Y or N	Diarrhea	Y or N	Pain During Sex
Y or N	Chest Pain	Y or N	Abdominal Pain		

Past Medical History/Illness: (Check all that apply)

__ Allergies	__ Diabetes	__ Asthma	__Accidents	__ Pneumonia
__ Nervous Problems	__ TB	__ Jaundice	__ Kidney Stone	__ Surgery
__ Shortness of Breath	__ Headaches	__	__ HIV/AIDS	__Stomach Ulcers
__ Rheumatoid Arthritis	__ Thyroid Disorder	__ Diabetes	__ Cancer, Type/Stage: _____	

Past Surgery: (Check all that apply)

__ Heart Bypass	__ Tubal Ligation	__ Hernia	__ Bowel Surgery	__ Appendectomy
__ Prostate	__ Joint Replacement	__ Fractures	__ Gallbladder Removal	__ Hysterectomy

__ Tendon/Ligament Repair __ Other: _____

Turn Page Over

Social History: (Circle Y or N)

Do you smoke? **Y / N** How much: _____ Have you ever smoked? **Y / N** How much: _____
Do you consume alcohol? **Y / N** How much: _____ Employment Status: **working**, **retired**, **disabled** Job: _____
Relationship Status: **single**, **married**, **divorced**, **widowed** Have Kids: **Y / N**

Circle Below:

Mother: Deceased (Yes or No) Age of death _____ Cause of death _____
Father: Deceased (Yes or No) Age of death _____ Cause of death _____

Family History: Who in your family has the following? (Please write M for Mother, F for Father)

____ Asthma	____ Diabetes	____ Heart Attack	____ High Cholesterol	____ Glaucoma
____ COPD	____ Kidney Failure	____ Stroke	____ High Blood Pressure	____ Vascular Disease
____ Bladder Cancer	____ Kidney Cancer	____ Prostate Cancer		

What pharmacy do you use? _____

Please list your medications and doses below: (Include any nonprescription medications)

_____

_____

Are you allergic to any medications? Yes or No

Please list medication allergies and your reaction: Nausea / itching / hives / difficulty breathing / other

_____

_____

Any allergy to: Iodine **Y / N** Metal **Y / N** Latex **Y / N**

Authorization, Assignment of Benefits, and Referral Medical Release:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly o Columbus Regional Health Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by the physicians of the nature and purpose of an proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: _____ Date: _____