Patient History

First Name	Middle Initial	Last Name	DOB

Address	City: State:	Zip Code	Primary #: Secondary #:

Religion	Occupation	Employer

Height	Social Security #	Marital Status S M D W	Family Physician	Email

Spouse/Guarantor

First Name	Last Name
Social Security #:	
DOB: Sex:	
Address	
City	State: Zip Code:
Phone (H) Phone (W)	

Insurance

Primary Insurance Carrier		ID #:	Group #:
Insurance Address		City	State: Zip Code:
Policy Holder/Insured	DOB	Policy Holder Employer	Relationship to Insured
Secondary Insurance Carrier		ID #	Group #
Insurance Address		City	State: Zip Code:
Policy Holder/Insured	DOB	Policy Holder Employer	Relationship to Insured

Medications/Allergies

Current Medications (Please List)

Drug Allergies (Please List)

Are you allergic to Latex? Y or N

Social History

Do you currently smoke? Y or N
If yes, how much? __________ How often? __________
If no, have you ever smoked? Y or N Last time________

Drink alcohol: Y/N How Much? ____ How Often? ___
Drink Caffeine: Y/N How Much? ____ How Often? ___

Family History (List any medical problems/illnesses)

Mother	Mother's Parents:
Father:	Father's Parents:
Siblings:	Aunts:
Cousins:	Uncles:

Gynecological History

Age menstruation began _________ Date of last menstrual Period _________	Interval of menses ________ Duration of menses _______	Have you ever had any exposure to: _____Gonorrhea _____Vaginal Warts _____Chlamydia _____Herpes _____DES

Contraception method: ________________
Have you previously used Oral Contraceptives?
Y or N How long? _________

Have you had a:
Mammogram? Y/N If yes, when? _________
Abnormal Pap? Y/N If yes, when? _______ How was it treated? _____
Date of last pap: ________________

Obstetrical History (List most recent first)

Date	Delivery Type	Anesthesia	Baby's Weight	Sex (M/F)	Complications

Miscarriages/Abortions

Date	Weeks pregnant	Complications	Hospital	Physician

Surgical History (List all surgeries)

Date	Surgery	Physician	Hospital	Complications

Medical History (Do you have a history of any of the following? If yes, please explain briefly below).

O Hypertension | O Heart Problems | O Diabetes | O Asthma | O Thyroid Problem | O Heart Burn

O Kidney Problems | O Kidney Stones | O Bladder infection | O Stress Incontinence | O Pain with urination | O Urinary Tract Infection

O Colitis | O Constipation | O Rectal Bleeding | O Hemorrhoids | O Migraines | O Seizures | O Anxiety | O Depression

O Phlebitis or blood clots | O varicose Veins | O Anemia | O Blood Transfusion

O Chicken Pox | O Rubella/Measles | O Tuberculosis | O Hepatitis

O HIV | O Arthritis | O Other: (Please List) ______________________________

____

Please list major injuries: ______________________________

____

____

Do you have pain? Yes or No
If yes, please rate level of pain:
Least painful Most painful
1 2 3 4 5 6 7 8 9 10

Insurance Payment

I request that payment to the authorized Insurance Carrier (or) Medicare listed above benefits be made either to me or on my behalf to the name of the provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service.

Signature______________________________ Date ______________________

All About Women of Christiana Care, Inc. Obstetrics & Gynecology

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