

HEART OF FLORIDA OB/GYN ASSOCIATES

All information is confidential

ACCT#: _____

GENERAL PATIENT INFORMATION

Last Name _____ First _____ MI _____

Sex F _____ M _____ Date of Birth *mm/dd/yyyy* _____ Age _____

Social Security Number _____ - _____ - _____ Status _____ Single _____ Married _____ Widowed

Mailing Address: _____

Phone Home(_____) _____ - _____ Work(_____) _____ - _____

Phone Cell(_____) _____ - _____ Other(_____) _____ - _____

Email Address _____

(ONLY to be used in emergent cases for the office to contact the patient if all other methods fail)

How did you hear about our office? _____

INSURANCE INFORMATION-*Must present card to staff for copy/image*

PRIMARY INSURANCE _____

Effective Date *mm/dd/yyyy* _____ ID# _____

Insured's Name: _____

Insured's DOB *mm/dd/yyyy* _____ Relationship _____ Self _____ Spouse _____ Other

SECONDARY INSURANCE _____

Effective Date *mm/dd/yyyy* _____ ID# _____

Insured's Name: _____

Insured's DOB *mm/dd/yyyy* _____ Relationship _____ Self _____ Spouse _____ Other

REFERRING PHYSICIAN/PRIMARY CARE PHYSICIAN

Physician Name _____ Phone(_____) _____ - _____

Address _____

OCCUPATION INFORMATION

Patient's Employer _____ Position _____

Phone(_____) _____ - _____ Full Time _____ Part Time _____ N/A _____

Spouse's Employer _____ Position _____

Phone(_____) _____ - _____ Full Time _____ Part Time _____ N/A _____

PRIMARY LANGUAGE

If other than English, please plan to bring an English speaking translator to the office with you. Some staff members speak Spanish and may be available but this office will not supply a translator.

EMERGENCY CONTACT INFORMATION

Whom should we contact in case of an emergency _____

Relationship to patient _____ Phone(_____) _____ - _____

ADVANCED DIRECTIVE

An advanced directive or "living will" provides written information or wishes of the patient to physicians, family members, etc. in case of an emergency that would render the patient "brain dead" or in a constant "vegetative state", depending on medical machinery, equipment, external feeding & hydration methods for life of the patient to continue.

PAYMENT METHOD

Please indicate type of payment _____ Cash _____ Check _____ Visa _____ Mastercard

HEART OF FL OB/GYN ASSOCIATES

Health History Form

Name: _____ D.O.B. _____

List any drug allergies and reactions:

Drug(s): _____ Reaction(s): _____

List any other allergies and reactions: _____

Have you had any special immunizations? What & when were they? (i.e. hepatitis, malaria, small pox)?

List any pertinent family history & relationship to you:

- | | | | |
|----------------|-----------------------------|----------------------------|---------------------------|
| 1-Cancer | 2-Congenital Heart Defect | 3-Thalassemia | 4-Neural Tube Defect |
| 5-Hemophilia | 6-Down Syndrome | 7-Tay Sachs | 8-Sickle Cell |
| 9-Diabetes | 10-Cystic Fibrosis | 11-Muscular Dystrophy | 12-Huntington Chorea |
| 13-Retardation | 14-Birth Defect | 15-Autism | 16-Psychological Disorder |
| 17-PKU | 18-Recurrent Pregnancy Loss | 19-Pregnancy Complications | |

Explain by # above: _____

MEDICAL HISTORY:

High Blood Pressure	Scarlet Fever	Bronchitis	Ulcers
Heart Disease	Polio	Sinusitis	Gallstones
High Cholesterol	Shingles	Asthma	Gastro-Intestinal Disease
Hepatitis	AIDS	Tuberculosis	Hemorrhoids
Rheumatic Fever	HIV	Pneumonia	Varicose Veins
Stroke	Diabetes	Pulmonary Disease	Cancer
Urinary Tract Infection	Thyroid Disease	Anxiety Attacks	Anemia
Kidney Disease	Autoimmune Disorder	Suicide Attempts	Migraines(diagnosed by
Epilepsy	Lupus	Psychological Disorder	a neurologist)

Other: _____

Surgeries & Hospitalizations:

Why:

Dates:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____ D.O.B: _____

SOCIAL HISTORY:

Do you smoke? Yes / No If yes, how much? _____ / day
Do you drink? Yes / No If yes, how much? _____ / day
Do you use any street drugs? Yes / No If yes, what & how much _____ / day

MEDICATION(S):

List all present medications & dosages:

MEDICATION AND DOSAGE	HOW /WHEN TAKEN	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY HISTORY:

How many pregnancies? _____ include miscarriage, stillbirth, etc.
How many children born: Alive: _____ Stillborn _____ Premature _____
Miscarriage _____ Abortions _____ Vaginal Births _____ Cesarean Sections _____
Complications: _____

MENSTRUAL HISTORY:

Age at first period: _____ # of pads/tampons used per cycle: _____ First day of last period: _____
Do you have regular cycles? Yes / No Do you have (circle all that apply) Clots / Cramps / Pain
Explain above (if necessary): _____
Do you have any vaginal discharge? Yes / No Color: _____ Amount _____
Odor: _____ Frequency _____

SEXUAL HISTORY:

Are you sexually active? _____ Birth Control Type: _____
How long on present birth control: _____

of Current Partners: _____ Male, Female, Both, Other: _____ Protection used? Yes / No
of Partners in last year: _____ Male, Female, Both, Other: _____ Protection used? Yes / No

Have you ever had any sexually transmitted disease? (Circle all that apply)
Syphilis Gonorrhea Chlamydia Genital Herpes Genital Warts Trichomonas Crabs HIV

Do you think you are at any increased risk for any sexually transmitted disease, HIV, hepatitis? _____

Have you had sex with any partner that is not from the United States in the past 2 years? _____

From what country/nation is/was your partner from? _____

Was a condom used? _____

Have you ever been treated for pelvic inflammatory disease? _____

(This office does not mean to offend anyone by asking the above questions)