obgyn partners of augusta

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465 North Belair Road, Suite 1B
Evans, Ga. 30809

New Patient Information

Have you ever been seen or treated by any of the physicians in our group previously?
Visit (Circle One)? Yes No
If yes, by which physician: _____ Date: _____ If no, how did you learn about OBGYN Partners of Augusta: _____
Doctor you are seeing today: _____

Patient Name: _____ SSN: _____
Date of Birth: _____ Age: _____
Nickname: _____ E-Mail: _____
Home Phone No: _____ Cell Phone No: _____
Address: _____ City, State: _____ Zip: _____
Employment Status (Circle One): Full time Part time Retired Student Other
Patient Employed By: _____ Phone No: _____
Occupation: _____
Preferred Pharmacy and Lab: _____
Marital Status (Circle One): Single Married Widowed Separated Divorced
Ethnicity (Circle One): African-American Asian Caucasian Hispanic/Latino Other _____

Emergency Contact: _____ Phone No: _____
Spouse/Responsible Party Name:_____ Relation to Patient: _____
Spouse Employer Name: _____ Phone No: _____
Spouse Date of Birth: _____ SSN: _____
Home Phone No: _____ Cell Phone No: _____

Primary Insurance Company: _____ Effective Date: _____
Member Name: _____ Member ID: _____
Group Name: _____ Group No: _____
SSN: _____ Date of Birth: _____ Relation to Patient: _____
Employer Name: _____ Phone No: _____

Secondary Insurance Company: _____ Effective Date: _____
Member Name: _____ Member ID: _____
Group Name: _____ Group No: _____
SSN: _____ Date of Birth: _____ Relation to Patient: _____
Employer Name: _____ Phone No:_____

*** Please complete front <u>and</u> back of each sheet ***

Name: _____ **DOB:** _____ **Age:** _____

Today's Date: _____ **Reason for visit:** _____

_____

_____

Screening Studies	**Date**	**Immunizations**	**Date**
Date of last Mammogram		HPV (Gardasil) Vaccine	
Date of last Bone Density		Influenza (flu injection)	
Date of last Colonoscopy		Pneumococcal Vaccine	
Date of last Pap Smear		Shingles Vaccine	
Date of last Chest X-Ray		Hepatitis	
Date of last EKG		TDAP	
Other:		Tetanus	
		Other:	

Gynecological History

Age at 1st Period: _____ Start Date of Last Period: _____

Periods are (circle): Regular Irregular Absent

How many days between the start of each cycle? _____ days

How many days do you bleed? _____ days

Flow (circle): Light Moderate Heavy

Cramps (circle): None Mild Moderate Disabling

Are you sexually active (circle)? Yes No

If no, have you been in the past (circle)? Yes No

If yes, (circle) with: Men Women Both

Current Method of Contraception: _____

Desired Method of Contraception: _____

Are you planning any (more) children (circle)? Yes No

Are you Menopausal (circle)? Yes No Date of onset: _____

Have you ever had a sexually transmitted disease (circle)? Yes No

Would you like screening for sexually transmitted diseases (circle)? Yes No

Have you ever had an abnormal pap smear (circle)? Yes No

If yes, please list treatment (if any) and date of treatment: _____

_____

Please check **Yes** or **No** if you have had any history of other gynecological problems

	Yes	**No**		**Yes**	**No**
Fibroids			Urinary leakage		
Endometriosis			Incontinence		
Ovarian Cysts			Overactive bladder (OAB)		
STD's			Other:		
Infertility					
Sexual dysfunction					

Please list known **allergies** to medication or substances (e.g. latex, iodine, etc.):

Drug Name	**Reaction you had**

*** Please complete front and back of each sheet ***

Please list all your medications. Remember to include any supplements you are taking.

Medication Name	Dosage	Physician prescribing this medication

Please list (below) any prior surgeries you have had.

Surgery/Reason	Date	Surgery/Reason (cont'd)	Date

Past Medical History									
Breast Cancer	□	Self	□	Family	Thyroid Disease	□	Self	□	Family
Colon Cancer	□	Self	□	Family	Kidney Disease	□	Self	□	Family
Ovarian Cancer	□	Self	□	Family	Kidney stones	□	Self	□	Family
Uterine Cancer	□	Self	□	Family	Recurrent bladder infections	□	Self	□	Family
Other Cancer	□	Self	□	Family	Stomach Ulcer	□	Self	□	Family
Heart Problems	□	Self	□	Family	Colitis	□	Self	□	Family
Mitral Valve Prolapse	□	Self	□	Family	Reflux Disease	□	Self	□	Family
High Blood Pressure	□	Self	□	Family	Diverticulosis	□	Self	□	Family
High Cholesterol	□	Self	□	Family	Irritable bowel disease	□	Self	□	Family
Stroke	□	Self	□	Family	Liver Disease	□	Self	□	Family
Bleeding or Clotting disorder	□	Self	□	Family	Hepatitis	□	Self	□	Family
Blood Clots in legs or lungs	□	Self	□	Family	Arthritis	□	Self	□	Family
Pulmonary Embolism	□	Self	□	Family	Osteoporosis (weak bones)	□	Self	□	Family
Sickle Cell Disease	□	Self	□	Family	Musculoskeletal disease	□	Self	□	Family
Blood Transfusion	□	Self	□	Family	Mental illness	□	Self	□	Family
Anemia	□	Self	□	Family	Depression	□	Self	□	Family
Asthma or Lung Disease, Sleep Apnea	□	Self	□	Family	Anxiety	□	Self	□	Family
Migraine Headaches	□	Self	□	Family	Schizophrenia	□	Self	□	Family
Seizures/Epilepsy	□	Self	□	Family	Eating Disorder	□	Self	□	Family
Diabetes	□	Self	□	Family	Substance abuse	□	Self	□	Family

If any are checked, please explain: _____

_____

_____

*** Please complete front <u>and</u> back of each sheet ***

Social History

Please circle one of each below or complete where necessary:

Married / Single / Divorced / Widowed (circle)

Tobacco Use (circle): **Current** **Former** **Never**

If current, age started: _____ Number of packs per day: _____

If former, age started: _____ Age stopped: _____

Do you drink Alcohol (circle): Yes / No Number of drinks per week: _____

Do you have a history of alcohol addiction (circle): Yes / No Details: _____

_____

Do you use recreational Drugs (circle): Yes / No

Do you have a history of Drug addiction (circle) Yes / No: Details: _____

Obstetric History

Total pregnancies:_____ Premature delivery (less than 37 weeks): _____

Full term births (more than 37 weeks): _____ Adoptive: _____

Miscarriages: _____ Abortions/Elective terminations:_____

Living children: _____

On the chart below, please fill in information for each pregnancy including abortions or miscarriages.

Number	Birthdate	Weeks	Sex	Weight	Vaginal or C-Section	Complications
1						
2						
3						
4						
5						
6						
7						
8						

If you are pregnant, please check if you, the father of the baby, or any blood relatives have the following:

Genetic Screening	Yes	No		Yes	No
Cystic Fibrosis			Recurrent pregnancy loss/stillbirth		
Down Syndrome, mental retardation,			Sickle Cell Disease or trait		
Heart defects at birth			Tay-Sachs Disease (Jewish, Cajun, French		
Hemophilia			Thalassemia (Italian, Greek,		
Huntington Chorea			Canavan's Disease		
Maternal metabolic disorder (Diabetes,			Other inherited genetic/chromosomal		
Muscular Dystrophy					
Patient or father of baby w/ birth defects not listed					

Patient Signature: _____ **Date:** _____

Consent:

I hereby authorize and consent to examination, treatment, release of medical information to my insurance company(ies), claim representatives, adjustors, and other physicians by OBGYN Partners of Augusta, P.C. I hereby assign all payments for medical services rendered by OBGYN Partners of Augusta, P.C. I understand that my demographic information is stored by the University Health Care System Data Repository.

Patient Signature: _____ **Date:** _____