Pearl OBGYN

PATIENT INFORMATION

Name (First, Middle, Last) _____

Date of Birth _____ Gender _____ F _____ M SSN _____

___ Married ___ Single ___ Widowed ___ Divorced / ___ Employed ___ Retired ___ Unemployed

Address _____

Home/Cell Phone _____ Work Phone _____

Email Address _____ Race _____

Patient Occupation _____

Emergency Contact _____ Relationship _____

Home/Cell Phone _____ Work Phone _____

Referring Physician _____ Primary Care Physician _____

Pharmacy Name _____ Pharmacy Crossroads _____

Is the patient the financially responsible party? ____ Yes ____ No

If no, Indicate the person who is _____ Relationship _____

PRIMARY INSURANCE:

Card Holder Name _____ Relationship _____

Card Holder DOB _____

Insurance Company _____ ID# _____ Group # _____

SECONDARY INSURANCE:

Card Holder Name _____ Relationship _____

Card Holder DOB _____

Insurance Company _____ ID# _____ Group # _____

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-ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:-

I acknowledge I have received a copy of Pearl OBGYN Notice of Privacy Practices effective 7/2021.

-AUTHORIZATION FOR MEDICAL CARE:-

I hereby authorize Pearl OBGYN to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment.

-REFERRAL WAIVER:

I acknowledge that in the course of my treatment, Pearl OBGYN, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. PEARL OBGYN will notify me when such a referral occurs. PEARL OBGYN assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Pearl OBGYN make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company. Pearl OBGYN is not responsible should my insurance process claims at the noncontracting level for the referred service(s).

-COMMUNICATION PREFERENCES:-

By signing below, I give permission to the person(s) listed to receive LIMITED information about my care. I understand my healthcare provider will utilize their professional judgment to ensure that information is shared with family/friends in order to assist with my continuing care. Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1.☐ Do NOT share ANY information with anyone.

2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: **Relationship:**

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

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3. Physicians/Providers:

☐ You may also share information, including medical records, with the following physicians/providers who participate in my care:

Name: **Name:**

Signature of Patient or Personal Representative _____

Printed Name_____ **Date** _____

If Personal Representative, Relationship to Patient:

#

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE OF SERVICE: _____

PHARMACY: _____

PROVIDER(Circle): Dr. Hershberger / Dr. Noteboom / Amanda Twist / Mindy Kile

Patient Health History

Reason for today's visit? _____

_____

Would you like to be tested for sexually transmitted infections? **Yes / No**

Age: _____ Last Menstrual Period: _____/_____/_____

Obstetrical History

Total Pregnancies: _____ Total Miscarriages: _____ Total Abortions: _____

Ectopic Pregnancy: _____ Children Living: _____

Date	Sex	Weight	Type of Delivery	Complications

Gynecologic History

1. How old were you when your periods began? _____
2. Are your periods regular? **Yes / No** How many days in cycle? _____
3. How heavy is your bleeding? _____ How many days of bleeding? _____
4. Do you have cramping? **Mild / Moderate / Severe**
5. Are you sexually active? **Yes / No** Do you have pain with intercourse? **Yes / No**
6. Age at first intercourse: _____ Total number of sexual partners: _____
7. Do you have any history of venereal disease such as gonorrhea, chlamydia, herpes, HPV, genital warts, or syphilis? _____
8. History of infection in the uterus and/or fallopian tubes? _____
9. History of sexual abuse: _____ History of physical abuse: _____
10. Date of last Pap smear: _____
11. Have you ever had an abnormal Pap smear? _____ When? _____
12. What is your birth control method: (please circle) none, condoms, spermicidal, foam, Depo-Provera, IUD, Nexplanon, birth control pills, birth control patch, birth control ring, tubal ligation, vasectomy, natural family planning. Are you satisfied with this method? **Yes / No**
13. Do you have history of breast disease? _____
14. Sexual Orientation: Heterosexual / Homosexual / Bisexual

Patient Name:_____ **Date of Birth:** _____

Personal Medical History

Please list current medications/dosage you are taking (please include supplements & over the counter medications):

_____
_____
_____

Please list allergies to medications:

_____
_____

Are you allergic to Latex? _____Yes _____ No

Have you ever had any unusual childhood illnesses, such as rheumatic fever or seizures? _____
_____

Who is your primary care physician? _____

Surgical History

Please list all surgeries you have had and approximate dates:

	Surgery	**Date**
1.		
2.		
3.		
4.		
5.		

Hospitalizations: (other than pregnancy):

1. _____
2. _____
3. _____

Trauma History: Please list any broken bones, concussions, or injuries you may have had in the past:

1. _____
2. _____
3. _____

Immunizations:

When was your last Tetanus vaccine? _____

Have you had the HPV vaccine? **Yes / No** Hepatitis B vaccine? **Yes / No**

Past Medical History

Have you ever had any unusual childhood illnesses, such as rheumatic fever or seizures?

a. Eye or visual problems: _____
b. Ear, nose or throat problems: _____
c. Thyroid disorders or diabetes: _____
d. Lung disease (such as Pneumonia, Bronchitis, Asthma): _____
e. Heart problems or high blood pressure: _____
f. Blood transfusion: _____
g. Liver or Gallbladder disease (such as Hepatitis, Jaundice or Gallstones): _____
h. Stomach disorders (such as Ulcers, Gastritis, Hiatal Hernia): _____
i. Intestinal disorders (such as Colitis, Spastic Colon, Polyps): _____
j. Recurrent Urinary Tract Infections or Incontinence: _____
k. Kidney Disease: _____
l. Anemia or blood clotting disorder:_____
m. Bone or joint disease (such as Arthritis or Osteoporosis): _____
n. Neurological problems (such as Migraines): _____
o. Mental disorders (such as Depression, Anxiety, Attacks, Nervous Breakdown): _____

Family History

Please list any family members with the following illnesses (Parents, Siblings, Grandparents, Aunts and/or Uncles; maternal mother and paternal father's sides of the family):

a. Cancer (include type of cancer): _____
b. Endometriosis: _____
c. Blood Disorders: _____
d. Lupus/Diabetes/Thyroid: _____
e. Birth Defects: _____
f. Heart Disease: _____

Social History

a. Cigarette Smoking: **Yes / No** Amount: _____ For how long? _____
b. Do you drink alcohol? **Yes / No** Amount: _____
c. History of drug use: **Yes / No** If yes, which drug? _____
d. Occupation or type of employment: _____

Testing

Date of last Mammogram:_____ Normal: **Yes / No** if no, results _____

Date of bone density: _____ Normal: **Yes / No** if no, results _____

Have you had any blood work, labs, or x-rays in the past year? **Yes / No** If so, please list:

_____

For those over 45, when did you have your last Sigmoidoscopy / Colonoscopy:

_____

REVIEW OF SYSTEMS: Check only the symptoms you experienced in the past 6 months.

General ☐ Weight Loss ☐ Weight Gain ☐ Fever / Chills ☐ Fatigue / Weakness	**Gastrointestinal** ☐ Change in appetite ☐ Difficulty Swallowing ☐ Abdominal Pain ☐ Nausea / Vomiting ☐ Bloating / Gas ☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Hemorrhoids ☐ Rectal Bleeding	**Gynecologic** ☐ Break Through Bleeding ☐ Labial Sores ☐ Labial Lumps / Nodules ☐ Vaginal Discharge ☐ Vaginal Itching ☐ Painful Intercourse ☐ Menstrual Cramps ☐ Pain between Periods ☐ Postmenopausal Bleeding ☐ Irregular Menses ☐ Loss of Sexual Desire ☐ Night Sweats ☐ Vaginal Odor ☐ Pelvic Pain ☐ Infertility Issues
Neck ☐ Stiffness ☐ Soreness ☐ Pain ☐ Masses		
Eyes ☐ Blurred / Double Vision ☐ Glaucoma / Cataracts ☐ Dry / Itchy Eyes ☐ Eyeglasses / Contacts	**Heart** ☐ Murmur ☐ Irregular Heartbeat ☐ Palpitations ☐ Chest Pain	**Musculoskeletal** ☐ Muscle Pain / Cramps ☐ Weakness ☐ Joint Pain / Swelling
Ears ☐ Hard of Hearing ☐ Hearing Changes ☐ Ringing in ears ☐ Ear Discharge ☐ Earache ☐ Dizziness	**Breast** ☐ Nipple Discharge ☐ Lumps / Nodules ☐ Pain / Tenderness ☐ Breast Masses ☐ Nipple Bleeding	**Psychiatric** ☐ Depression ☐ Irritability ☐ Anxiousness ☐ Alcohol Abuse ☐ Suicidal Thoughts ☐ Sexual Difficulties ☐ Panic Attack ☐ Drug Addiction ☐ Physical Abuse
Nose ☐ Sinus Congestion ☐ Runny Nose ☐ Postnasal Drip	**Genitourinary** ☐ Urgency ☐ Incontinence ☐ Urinary Frequency ☐ Pain with Urination ☐ Bloody Urine ☐ Urination at Night	**Endocrine** ☐ Heat Intolerance ☐ Cold Intolerance ☐ Loss of Hair ☐ Extreme Thirst ☐ Excessive Hair Growth ☐ Hypoglycemia / Low Blood Sugar
Mouth ☐ Bleeding Gums ☐ Oral Sores / Ulcers ☐ Dental Issues ☐ Loss of Taste	**Blood** ☐ Anemia ☐ Prolonged Bleeding ☐ Swollen Lymph Nodes ☐ Painful Lymph Nodes	**Neurological** ☐ Seizures ☐ Vertigo ☐ Paralysis ☐ Tingling / Numbness
Throat ☐ Difficulty Swallowing ☐ Throat Pain ☐ Hoarseness	**Lungs** ☐ Cough ☐ Shortness of Breath ☐ Wheezing	