

Great Neck OB/GYN Patient Information & Insurance Form

(Please Print Only)

Date: _____

PATIENT INFORMATION:

Name: _____ Home Phone: _(_____)_____

Street Address: _____ Work Phone: _(_____)_____

City: _____ State: _____ Zip: _____ Cell Phone: _(_____)_____

Email Address: _____ Pharmacy Phone: _(_____)_____

Date of Birth: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Referred by: _____

Mother & Father's First Names: _____ *(for identification only)*

Information Regarding Spouse and/or Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____

Cell Phone: _(_____)_____

INSURANCE INFORMATION

» Please have your insurance card with you and present it to front desk with this form.

Primary Insurance:

Insurance Carrier: _____ ID# _____

Insured Party: _____ Relationship to Patient: _____

Insured Parties D/O/B: _____

Secondary Insurance:

Insurance Carrier: _____ ID# _____

Insured Party: _____ Relationship to Patient: _____

Insured Parties D/O/B: _____

Great Neck OB/GYN Patient Medical Questionnaire

To our patients at Great Neck Obstetrics & Gynecology:

We kindly ask you to fill out the following form to assist us in updating your medical record. Please be as complete as possible. Thank you!

Name: _____ D/O/B: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: (Home) _____ (Work) _____

(Cell) _____ (Your Pharmacy) _____

Email: _____ Referred by: _____

Date of last Menstrual period: _____

1) Date of Last Mammogram: _____ Date of Last Bone Density: _____

Date of Last Colonoscopy: _____ Date of Colposcopy: _____

Date of Last Breast Ultrasound: _____ Date of Last Pelvic Sono: _____

2) Do you have any medical problems? Circle all that apply

ASTHMA/LUNG DISEASE

ANEMIA

OSTEOPOROSIS/PENIA

ARTHRITIS

ALLERGIES

STROKE

ANXIETY

COLON CANCER

BLEEDING DISORDERS

BREAST CANCER

CHOLESTEROL

IMMUNE DEFICIENCY

COLITIS

DIABETES

DEPRESSION

BLOOD CLOTS

EMPHYSEMA

FIBROMYALGIA

HEART ATTACK

HEPATITIS

HEART DISEASE

HYPERTENSION

KIDNEY DISEASE

JAUNDICE/HEPATITIS

MIGRAINE

MULTIPLE SCLEROSIS

MITRAL VALVE PROLAPSE

MENTAL HEALTH ISSUE: _____

THYROID DISEASE

IRRITABLE BOWEL SYNDROME

REFLUX/GASTRITIS

RHEUMATOID DISEASE

STOMACH ULCERS

SEIZURES

Please list any Medical Problems you have that are not listed above:

Great Neck OB/GYN Patient Medical Questionnaire

3) Current and past gynecologic conditions (Circle all that apply):

Abnormal Paps, if so any treatment? _____

DES Exposure

Painful intercourse

Ectopic Pregnancy

Endometriosis

Heavy, Painful Periods

Fibroids

STD's: Gonorrhea Chlamydia Syphilis Herpes

PMS

Irregular Cycles

Infertility, if so for what reason? _____

Ovarian cysts

Pelvic Inflammatory Disease

Cancer of: Breast Ovary Uterus Cervix

Recurrent Miscarriages

Urinary frequency or accidental loss of urine

Contraception:

Type of Contraception _____

IUD Type and insertion date (if applicable) _____

4) Please list any allergies to medications and/or latex below:

5) OB/GYN history:

How many pregnancies have you had? _____

Year of Birth	Hospital	Full Term/Pre Term Number Of Weeks	Vaginal, Vacuum, Forceps or Cesarean	Birth Weight	Sex of child
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list any miscarriages or abortions:

Year	# of weeks pregnant	D&C or not
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any complications during pregnancy or childbirth?

Great Neck OB/GYN Patient Medical Questionnaire

6) Please list all previous surgeries including gynecologic surgeries listed below. (Circle those that apply.)

- | | |
|-------------------|------------------------------------|
| D and C | Removal of ovary (right/left/both) |
| Hysterectomy | Myomectomy |
| Tubal ligation | Endometrial ablation |
| Cryosurgery | LEEP of cervix |
| Bladder prolapsed | Laparoscopy for: _____ |
| Breast surgery | C-section |

Year performed	Type of Surgery	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

7) Please list any medications you are currently taking:

8) FAMILY HISTORY: Are there any diseases that run in the family?

Please mark below which family members have a particular disease. (You may abbreviate, *M* for Mother, *F* for Father and *Sib* for sibling. For extended family, please mark Maternal or Paternal, for example *MG* for Maternal Grandmother).

- | | |
|---------------------------|---------------------|
| Diabetes _____ | Heart Disease _____ |
| Ovarian Cancer _____ | Breast Cancer _____ |
| Uterine Cancer _____ | Colon Cancer _____ |
| High Blood Pressure _____ | |

For Obstetrical patients only:

Is there anyone on your side or husband's side of the family with the following?

(Please list which family member and the condition.)

- Genetic Diseases _____
- Birth Defects _____
- Mental Retardation _____

9) Do you have any of the following habits? (Circle all that apply,)

- Smoking: packs/week _____ how many years _____
- Alcohol: drinks/week _____
- Drugs: What kind _____ how often? _____
- What kind _____ how often? _____

10) Type of employment _____