MONTEMURRO OBGYN

Name:______________________________ DOB:_______________ Social Sec #______________________________

Street Address:________________________ City:________________ State:______ Zip Code:___________________

Home Number:____________________ Cell Number:____________________ Work Number:___________________

Employer:____________________ Occupation:__________________ Email Address:_________________________

Emergency Contact and phone number:____

Medical Insurance:______________________________ Policy Number:_____________________________________

Policy Holder Name:____________________ Policy Holder DOB:_________ Secondary Insurance:______________

Family Physician Name:_______________________ How did you hear about us?____________________________

Previous OB/GYN:____

Reason for visit:____

Allergies to medications or foods:____

Current Medications:____

Pharmacy:____

FAMILY HISTORY:
Please describe any significant medical issues in your family.

Relationship	Living/deceased:	Illness:
________________________	___________________	____
________________________	___________________	____
________________________	___________________	____

Past and current medical problems:____

____

MENSTRUAL HISTORY:

LMP:_________________ Approximate:_______ Unknown: _______ Definite:_______

Frequency:______________ quality/quantity same monthly:___YES ___NO Flow:__mild __moderate __heavy

GYNECOLOGICAL HISTORY:

Date of last pap smear:________________ ____NORMAL ____ABNORMAL

Age of first period:____________________ Age of menopause:____________________

Have you had any of the following: (please check any that apply)

____HPV ____Colposcopy ____LEEP ____Cryosurgery ____Cone Biopsy ____Endometriosis ____Fibroids

____Dysmenorrhea ____Ovarian Cysts/tumors ____PID ____Reproductive Anomalies ____Infertility

OB HISTORY:

Total Number of Pregnancies:_______ Total Number of Children Living:__________________

Please check any history of the following that apply to your pregnancies/children:

____Miscarriages ____Terminations ____Ectopic Pregnancy ____Gestational Hypertension ____Preeclampsia

____Shoulder Dystocia ____Intrauterine Growth Retardation ____Gestational Diabetes

Year	Gestational Age	Baby's Weight	Vaginal Delivery/C-section
________	________________________	___________________________	____
________	________________________	___________________________	____
________	________________________	___________________________	____
________	________________________	___________________________	____
________	________________________	___________________________	____
________	________________________	___________________________	____

SOCIAL HISTORY:

Tabaco – Type:_________________ Last Used:__________ Daily Usage:__________

Alcohol – Type:_________________ Last Used:__________ How many daily:__________

Caffeine (check those that apply):___Coffee ___Tea ___Chocolate ___Energy Drinks Frequency:______________

Exercise:________________ Frequency:________________________________

Marital Status:___________ Occupation:________________________________

SEXUAL HISTORY:

Are you currently sexually active:_______ Age at first intercourse:________________

Partners (check those that apply): ____Men ____Women ____Both

Have you ever been diagnosed with a sexually transmitted infection? ____Yes ____No

If so, which on and when?____

When was the last time you were tested for HIV or and STI:____

SURGICAL HISTORY

Please name any previous surgeries and approximate dates

____

____

I authorize payment directly to my doctor and I authorize the doctor to act as my agent to obtain payment. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by my insurance. I authorize release of information to my insurance carrier and the use of this signature on all my insurance submissions.

____

Patient or authorized person's signature **Date**