



MIDTOWN

OBSTETRICS & GYNECOLOGY
4600 HALE PARKWAY SUITE 400
DENVER, COLORADO 80220
phone 303.321.2166 fax 303.861.7211
WWW.MYMIDTOWNOBYN.COM

Today's Date _____

PATIENT NAME:

Name (Legal) Last _____ First _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Pager _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Occupation _____ Employer _____

Spouse _____ Employer _____ Work Phone _____

Relationship to Responsible Party Self Spouse Son Daughter Other

RESPONSIBLE PARTY: (Person who should receive the bill)

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Date Of Birth _____ Age _____ Employer _____

REFERRED BY: _____

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance _____ Secondary Insurance _____

ID/Policy # _____ Suffix _____ ID/Policy # _____ Suffix _____

Group # _____ Group # _____

Claims Address: _____ Claims Address: _____

Claims Phone: _____ Claims Phone: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Date of Birth: _____ Date of Birth: _____

Phone: Area () _____ Phone: Area () _____

Employer: _____ Employer: _____

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name _____ Relationship _____ Phone _____

CONSENT FOR TEST RESULTS I give Midtown Obstetrics and Gynecology permission to leave all X-ray, lab results, test results, and other medical information and advice on: (check all that apply)

Voice mail at work Answering machine at home Other _____ Do not leave message

PATIENT and/or INSURED AUTHORIZATION

With my signature below I hereby authorize all of my insurance companies to make payment directly to Midtown OB/GYN. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance company. I authorize the release of any medical information necessary to process these claims.

PATIENT SIGNATURE: _____ DATE: _____

PERSONAL HEALTH HISTORY

Please complete the entire form, all information is confidential.

NAME _____ NICKNAME _____
TODAY'S DATE _____ DATE OF BIRTH _____ AGE _____

MENSTRUAL HISTORY

Date last period began _____ Was it normal? ___ No ___ Yes
How many days do your periods last? _____
How many days from the start of one period until the start of the next? _____
Do you have any problems with your period? ___ No ___ Yes If yes, what? _____
Do you take hormones? ___ No ___ Yes
Date of last Pap _____ Have you ever had an abnormal Pap? ___ No ___ Yes If yes, when? _____

PREGNANCY HISTORY

Total number of pregnancies: _____
Live births ___ Cesareans ___ Stillbirths ___ Abortions ___ Miscarriages ___ Ectopics ___ Living Children _____
Describe any problems with past pregnancies: _____
Are you currently pregnant? ___ No ___ Yes
Are you currently attempting to conceive? ___ No ___ Yes If yes, for how long? _____

SEXUAL HISTORY

Are you sexually active? ___ No ___ Yes If yes, is your partner: ___ Male ___ Female
How many partners have you had in the last year? _____
Have you ever had a STD? ___ No ___ Yes If yes, what? _____

CONTRACEPTIVE HISTORY

What method(s) of birth control are you currently using? _____
How long have you been using your current method(s) of birth control? _____
Do you have any problems with your current method(s)? ___ No ___ Yes If yes, what? _____
Do you want birth control now? ___ No ___ Yes If yes, which method? _____

PERSONAL MEDICAL HISTORY

Please List ALL previous surgeries: _____
Have you ever had a serious illness? ___ No ___ Yes If yes, please list: _____
Do you have current medical problems? ___ No ___ Yes
If yes to above, please specify (including asthma, thyroid, high blood pressure, etc.): _____
Do you currently take any prescription medications or over-the-counter supplements? ___ No ___ Yes
If yes, please list: _____

Do you take a daily calcium supplement? ___ No ___ Yes
Are you **allergic** to any medications or to Latex? ___ NO ___ Yes If yes, please list: _____

FAMILY HISTORY

Have any of your blood relatives had a serious medical problem? ___ No ___ Yes
If yes, please specify: _____
Do you have a family history of: ___ Ovarian cancer ___ Breast cancer ___ Colon cancer ___ Thyroid disease

SOCIAL HISTORY *Do you:*

Exercise? ___ No ___ Yes If yes, what type of activity and how often? _____
Smoke? ___ No ___ Yes If yes, how much? (day/wk/mo) _____ For how many years? _____
Drink alcohol? ___ No ___ Yes If yes, how much? (day/wk/mo) _____ For how many years? _____
Use recreational drugs? ___ No ___ Yes If yes, what and how often? (day/wk/mo) _____

MEDICAL UPDATES *Have you had a:*

		Dates, if known:
Cholesterol screen in the last 5 years?	___ No ___ Yes	_____
Fasting glucose test in the last 3 years?	___ No ___ Yes	_____
Thyroid screen in the last 5 years?	___ No ___ Yes	_____
Colonoscopy or stool test for blood?	___ No ___ Yes	_____
Bone density screening?	___ No ___ Yes	_____
Mammogram?	___ No ___ Yes	_____
Have you been vaccinated against HPV?		
When was your last Tetanus vaccine?	_____	

Do you have any medical issues you want to discuss today? If yes, please specify: _____