Cartersville OB/GYN Associates
Patient Information Sheet

(Please Print) Today's Date_____

Name_____**Age**_____**Birth Date**_____

Address_____Apt#____City_____State_____Zip_____

Home Phone_____Cell Phone_____SS#_____

Employer_____Work Phone_____

Address_____City_____State_____Zip_____

Marital Status (*Circle One*) Single Married Widowed Divorced Separated

Husband's Name (*if applicable*)_____Birth Date_____

Employer_____Work Phone_____SS#_____

Emergency Contact_____Relation_____

Cell Phone_____Home Phone_____

Do you have medical insurance?_____If so, please list below:

1. Name of Insurance Company_____
   Insured Name_____Insured Birth Date_____
   Insured SS#_____Member #_____Group #_____
2. Name of Insurance Company_____
   Insured Name_____Insured Birth Date_____
   Insured SS#_____Member #_____Group #_____

I authorize the release of any medical information necessary to process my claims.
I also assign payment for all medical services to Cartersville OB/GYN Associates, P.C., or any providers working on their behalf.

_____
(Patient's Signature)

All patients are requested to pay at the time of their visit.
We accept checks, cash, VISA or Mastercard.

CARTERSVILLE OB/GYN ASSOCIATES

CARTERSVILLE PROFESSIONAL BUILDING #2, SUITE 102
958A JOE FRANK HARRIS PARKWAY
CARTERSVILLE, GEORGIA 30120
770-386-4824

PLEASE PRINT CLEARLY

Name _____
Home Phone _____
Work Phone _____
Address _____
City _____ Zip _____
Birthdate _____
Referring Physician _____

Today's date _____
Emergency Contact _____
Home phone _____
Work Phone _____
Address _____
City _____ Zip _____

DRUG ALLERGIES

Check any medications you are allergic to:

- ❑ Aspirin
- ❑ Codeine
- ❑ Iodine
- ❑ Methergine
- ❑ Novacaine
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Tylenol
- ❑ Valium

Other _____

List any prescription, non-prescription, herbal or street drugs you are now using. Include antibiotics, anticoagulants/blood thinners, antihistamines, anti-seizure drugs, birth control pills, copper or progestaert IUD, narcotics, painkillers, or tranquilizers: _____

Menstrual Cycle

Do you usually have periods? . . . . . Yes❑ No❑
If so How often? _____
How long do they last? _____
Date of last period? _____
Age when started first period? _____
In general do you think that your periods and irregular? . . . . . Yes❑ No❑
Do you skip periods? . . . . . Yes❑ No❑
Do you have painful periods? . . . . . Yes❑ No❑
Describe _____
Any recent changes in pain? . . . . . Yes❑ No❑
Describe _____
Do you bleed between periods? . . . . . Yes❑ No❑
Do you ever have pain _____ or bleed _____ during or after sexual activity? . . . . . Yes❑ No❑
Describe _____

Pregnancy

Have you ever been pregnant? . . . . . Yes❑ No❑
How many births have you had? _____
Date of most recent birth _____
How many abortions and how many miscarriages have you had? _____
Have you had and complications of pregnancy? Include heav bleeding, infection, Caesarean section, toxemia or high blood pressure. Describe _____

Are you currently breast feeding Yes❑ No❑
Have you had german measles (rubella) Yes❑ No❑
Are you considering getting pregnant in the next year or so? Yes❑ No❑
Do you have Rh negative blood? Yes❑ No❑
If so have you ever been exposed through pregnancy to Rh positive blood? Yes❑ No❑
Have you ever received RhoGAM? Yes❑ No❑

Pap Smear Results

Was your last Pap smear normal? Yes❑ No❑
Date of last Pap smear
Have you ever had an abnormal Pap smear? Yes❑ No❑
Date _____ Results _____
Action taken: Include repeat Pap smear, colposcopy biopsy, cauterization, etc., date and results _____

Hormone-like Drug Use

Did your mother, while pregnant with you take diethysilbesterol (DES) ? Yes❑ No❑ Don't know❑
Did your mother take any anti-miscarriage or other drugs while pregnant with you? Yes❑ No❑ Don't know❑
List drugs _____

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Birth Control

List any birth control method you have used or are using:

Method Dates Used Problems/Benefits

_____

_____

_____

_____

_____

Have you ever had any of the following conditions? Please note date and treatment:

Gynecological Health Condition

Infection of uterus, tubes, or ovaries (PID)_____ Yes ☐ No ☐
Chlamydia_____ Yes ☐ No ☐
Gonorrhea_____ Yes ☐ No ☐
Syphillis_____ Yes ☐ No ☐
Vaginal yeast_____ Yes ☐ No ☐
Vaginal Trichomonas_____ Yes ☐ No ☐
Vaginal bacteria infection or non-specific infection_____ Yes ☐ No ☐
Excessive uterine bleeding_____ Yes ☐ No ☐
Breast lumps or cysts_____ Yes ☐ No ☐
Herpes_____ Yes ☐ No ☐
Genital sores_____ Yes ☐ No ☐
Venereal warts_____ Yes ☐ No ☐
Bladder infection_____ Yes ☐ No ☐
Kidney problems_____ Yes ☐ No ☐

General Health Conditions

Ulcers_____ Yes ☐ No ☐
Gall bladder problems_____ Yes ☐ No ☐
Hepatitis or liver disease_____ Yes ☐ No ☐
Heart trouble_____ Yes ☐ No ☐
Diabetes_____ Yes ☐ No ☐
Epilepsy_____ Yes ☐ No ☐
Anemia_____ Yes ☐ No ☐
High blood pressure_____ Yes ☐ No ☐
Varicose veins_____ Yes ☐ No ☐
Blood clots_____ Yes ☐ No ☐
Lung disease_____ Yes ☐ No ☐
Hypoglycemia (low blood sugar)_____ Yes ☐ No ☐
Blurred vision_____ Yes ☐ No ☐
Frequent headaches_____ Yes ☐ No ☐
Migraines_____ Yes ☐ No ☐
Thyroid problems_____ Yes ☐ No ☐
Skin conditions_____ Yes ☐ No ☐
Tumors_____ Yes ☐ No ☐
Cancer_____ Yes ☐ No ☐
Other_____

_____

_____

_____

Have you ever been hospitalized?..... Yes ☐ No ☐
If so, dates and reasons:_____

_____

_____

Have you ever had surgery?..... Yes ☐ No ☐
If so, dates and reasons:_____

_____

_____

Are you under another physician's care? Yes ☐ No ☐
If so, dates and reasons:_____
Name and address of physician_____

_____

Family Health Background

Do your blood relatives have the following?
Please note which relative.

Cancer_____ Yes ☐ No ☐
Diabetes_____ Yes ☐ No ☐
Heart disease_____ Yes ☐ No ☐
Down's Syndrome_____ Yes ☐ No ☐
Tay-Sachs_____ Yes ☐ No ☐
Sickle-cell disease_____ Yes ☐ No ☐
Breast disease_____ Yes ☐ No ☐
High blood pressure_____ Yes ☐ No ☐
Other_____

_____

_____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how much?_____
Have you ever smoked? ☐ Yes ☐ No
Do you drink? ☐ Yes ☐ No If yes, how much?_____
Do you use street drugs? ☐ Yes ☐ No

Patient _____ Date_____
MD_____ Date_____
Update_____ Date_____
MD_____ Date_____

CARTERSVILLE OB/GYN ASSOCIATES

Patient's name _____
Date of Birth _____

ACKNOWLEDGEMENT OF HIPAA RIGHTS

I do hereby acknowledge that Cartersville OB/GYN Associates has provided me with a notice of its privacy practices, as required by Federal law (HIPAA). I understand that Cartersville OB/GYN will, upon request, provide me with a copy of the privacy policy.

Signed_____
Date_____

CONFIDENTIALITY NOTICE

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW

_____ You may discuss my medical information **ONLY** with me.
_____ You may discuss my medical information with the following people:

	Name	Relationship	Phone#
1.			
2.			
3.			

_____ You may leave medical information (test results, etc.) on my voice mail at: **Cell #**_____ **Home#**_____

_____ You may contact me at **email** address:_____

Consent for medication history

I give consent for the medical staff of Cartersville Ob/Gyn Associates to obtain my complete medication history in order to provide the safest care possible.

Patient's signature _____