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OBSTETRICS AND GYNECOLOGY
6555 FRANK AVE N.W. NORTH CANTON, OHIO 44720

Date:__________

Last Name:	First Name, Middle Initial:	Maiden Name:
Mailing Address:		City / State / Zip Code:
Date of Birth:	Social Security Number:	Email Address:
Home Phone:	Cell Phone:	Preferred Language:
Marital Status: (Please check) ____Single ____Married ____Divorced ____ Separated ____Widowed	Race: (Please check) ____American Indian or Alaska ____Native Asian ____Black or African American ____Caucasian ____Bi-Racial	Ethnicity: (Please check) ___Hispanic/Latino ___Not Hispanic or Latino
Employer:	Work Phone:	Work Address:
Emergency Contact (Name & Relation):	Emergency Contact Number:	
Referred By:	Preferred Pharmacy:	Primary Care Doctor:
Spouses Name:	Spouses Cell Phone:	
Spouses Employer:	Spouses Work Phone:	

Primary Insurance Information		Secondary Insurance Information	
Policy Holder:		Policy Holder:	
Date of Birth & S.S #:		Date of Birth & S.S #:	
Insurance Provider:		Insurance Provider:	
Effective Date:	Expiration Date:	Effective Date:	Expiration Date:
Policy ID #:		Policy ID #:	
Group Name or #:		Group Name or #:	
Copay Amount:		Copay Amount:	

By signing below, you acknowledge receipt or have read our financial policy on our website under "New Patient FYI Forms", and agree to the terms.

Signature:____ Date:______________

INTAKE HISTORY FORM

NAME: ______________________________ DATE OF BIRTH: __________

ALLERGIES:

1. ______________________ REACTION: ______________________
2. ______________________ REACTION: ______________________
3. ______________________ REACTION: ______________________
4. ______________________ REACTION: ______________________
5. ______________________ REACTION: ______________________

PAST MEDICAL HISTORY: (CIRCLE ALL THAT APPLY):

Glaucoma Stroke Hypothyroid(underactive) Hyperthyroid(overactive) Asthma Anemia Blood Clots
Heart Attack Heart Murmur High Blood Pressure High Cholesterol Diabetes Seizures/Epilepsy
Irritable Bowel Crohn's Disease Diverticulitis Stomach Ulcers Hepatitis HIV Kidney Infection/Stones
Other: ______________________________

____

Last Pap Smear: __________ (Normal / Abnormal) Last Mammogram: __________ (Normal / Abnormal)

Last Colonoscopy: __________ (Normal / Abnormal) Last Bone Density: __________ (Normal / Abnormal)

PAST SURGICAL HISTORY: (CIRCLE ALL THAT APPLY):

Gallbladder Appendix Umbilical Hernia Incisional Hernia Ablation Hysterectomy (Abdominal)
Hysterectomy (Vaginal) Hysterectomy (Laparoscopic) Right Tube/Ovary Out Left Tube/ Ovary Removed
Both Tubes/Ovaries Out Knee Hip Mastectomy Breast Lumpectomy Tonsils Tonsils & Adenoids
Wisdom Teeth Other: ______________________________

____

MEDICATIONS:

1. __________________	6: __________________
2. __________________	7: __________________
3. __________________	8: __________________
4. __________________	9: __________________
5. __________________	10: __________________

SOCIAL HISTORY (PLEASE CIRCLE):

SMOKE	NO	YES: Current or Former ______ Packs Per Day
ALCOHOL	NO	YES: Social Occasional Weekly Daily __________
DRUGS	NO	YES: __________________________

NAME: ____________________ DATE OF BIRTH: __________

FAMILY HISTORY: (Those not on Hereditary Cancer Questionnaire)

Blood Clots: ____________________

Heart Disease: : ____________________

Diabetes: : ____________________

High Blood Pressure: : ____________________

Osteoporosis: : ____________________

Strokes: : ____________________

Bleeding or Clotting Disorders: : ____________________

High Fever During Anesthesia: : ____________________

PLEASE CIRCLE ANY SYMPTOMS YOU CURRENTLY HAVE:

Weight Loss Weight Gain Fever Excessive Fatigue Double Vision Seeing Spots Ear Aches

Sore Throat Diarrhea Constipation Nausea/Vomiting Bloody Stools Shortness of Breath

Difficulty Breathing Chest Pain Heart Palpitations Swelling of Legs Wheezing Cough

Back Pain Swollen Lymph Nodes Muscle Weakness Dizziness Numbness Depression

Anxiety Hot Flashes Abnormal/Changing Moles Increased Thirst Increased Urination

Incontinence of Urine or Stool Pain with Urinating Urinary Urgency Waking to Urinate

Incomplete Bladder Emptying Vaginal Itching Vaginal Burning Vaginal Dryness

Pain with Intercourse Vaginal Lesions Pain with Menses Spotting Between Menses

MENSTRUAL HISTORY:

Age of First Menses: __________ Age at Menopause: __________

How far apart are periods?(Days): __________ How long do your periods last?(Days): __________

How long collectively, have you used birth control in your life? ◯ Less than 5 years ◯ More than 5 years

When is the last time you used birth control? ◯ Currently ◯ Less the 5 years ago ◯ More than 5 years ago

Total # Pregnancies: __________ #FullTerm: __________ # Preterm: __________ #Living Children __________

#Miscarriages: __________ #Abortions: __________ #Ectopic: __________ #Multiple Births: __________

YEAR	WEEKS PREGNANT	DELIVERY TYPE	COMPLICATIONS	WEIGHT	SEX