WILLIAM C. TO, M.D. FACOG

PATIENT INFORMATION

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LAST NAME		FIRST NAME & INITIAL		MARRIED	SINGLE	DIVORCED	WIDOWED
BIRTHDATE	AGE	SOCIAL SECURITY	DRIVER'S LICENSE		MEDICAL RECORD (OFFICE USE)		
ADDRESS			CITY	STATE		ZIP	
HOME PHONE	BUSINESS PHONE	CELL PHONE	EMAIL	PREFERRED CONTACT			
				HOME	BUSINESS	CELL	EMAIL
EMPLOYER			OCCUPATION				
BUSINESS ADDRESS			CITY	STATE		ZIP	
SPOUSE/PARTNER NAME			BIRTHDATE				
SPOUSE/PARTNER EMPLOYER			OCCUPATION	PHONE			
EMERGENCY CONTACT							
NAME		RELATIONSHIP		CONTACT			
YOU ARE REFERRED BY							
NAME OF YOUR OTHER PHYSICIANS							
INSURANCE INFORMATION 1							
NAME OF INSURANCE			INSURANCE NUMBER				
ADDRESS				PHONE			
POLICY'S HOLDER'S NAME			RELATIONSHIP	PHONE			
INSURANCE INFORMATION 2							
NAME OF INSURANCE			INSURANCE NUMBER				
ADDRESS				PHONE			
POLICY'S HOLDER'S NAME			RELATIONSHIP	PHONE			
ASSIGNMENT OF BENEFITS							
I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENT HAVE BEEN MADE. IN THAT CASE THE FOLLOWING WILL APPLY. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO WILLIAM C. TO, M.D. OF THE INSURANCE BENEFITS OTHERWISE PAYBABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.							
SIGNATURE			DATE				
AUTHORIZATION TO RELEASE INFORMATION							
I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.							
SIGNATURE			DATE				

MEDICAL HISTORY

NAME:_____ AGE:_____ DATE:_____

GENERAL MEDICAL HISTORY: Do you have or have you had any of the following?

NO	YES	NOW		NO	YES	NOW	
____	____	____	Anemia	____	____	____	Rubella
____	____	____	Bladder infection	____	____	____	Seizure
____	____	____	Blood clots in vein	____	____	____	Depression
____	____	____	Cancer	____	____	____	Shortness of breath
____	____	____	Diabetes	____	____	____	Bowel problem
____	____	____	Genetic disease/birth defects	____	____	____	Stroke
____	____	____	Headaches	____	____	____	Swollen legs or ankles
____	____	____	Heart disease	____	____	____	Thyroid disease
____	____	____	Hepatitis/liver disease	____	____	____	Tuberculosis
____	____	____	High blood pressure	____	____	____	Varicose veins
____	____	____	Hospitalizations	____	____	____	Vertigo
____	____	____	Kidney disease	____	____	____	Visual problems
____	____	____	Liver or gall bladder	____	____	____	Warts
____	____	____	Lung disorder				Other illness:_____
____	____	____	Mononucleosis				_____
____	____	____	Obesity				_____
____	____	____	Rheumatic fever				

Allergy: _____ Surgery: _____

Medications: _____

FAMILY HISTORY: Has any member of your family had any of the following?

NO	YES	FAMILY MEMBER		NO	YES	FAMILY MEMBER	
____	____	____	Bleeding problems	____	____	____	High blood pressure
____	____	____	Blood clots in veins	____	____	____	High cholesterol
____	____	____	Breast cancer	____	____	____	Psychiatric problems
____	____	____	Cervical cancer	____	____	____	Sickle cell disease
____	____	____	Diabetes	____	____	____	Stroke
____	____	____	Fibroid tumors	____	____	____	Tay Sachs disease
____	____	____	Gall bladder disease	____	____	____	Tuberculosis
____	____	____	Heart attacks	____	____	____	Twins
							Other illness:_____
							_____

Did your mother take hormones during pregnancy to prevent miscarriages? Yes____ No____ Don't know____

GYNECOLOGICAL HISTORY: Do you have or have you had any of the following?

NO	YES	NOW		NO	YES	NOW	
____	____	____	Abdominal pain	____	____	____	Bleeding with intercourse
____	____	____	Abnormal pap smear	____	____	____	Breast lumps or discharge
____	____	____	Abortion complication	____	____	____	Herpes infections
____	____	____	Bleeding between periods	____	____	____	Infertility

NO	YES	NOW		NO	YES	NOW	
____	____	____	Irregular periods	____	____	____	Surgery:breast or pelvic
____	____	____	Menstrual problems	____	____	____	Vaginal infections
____	____	____	Pelvic infections	____	____	____	Venereal warts
____	____	____	Premenstrual problems				Other illness:_____
____	____	____	Sexually transmitted disease				_____
							_____

MENSTRUAL HISTORY

Age period started:_____
First day of last period:_____First day of previous period:_____
Regular:_____Irregular:_____
Amount of bleeding (flow): number of pads or tampons used in 24 hour period on heavy day of flow_____
Cramping:___mild ___moderate ___severe for ___days
Other menstrual concerns:_____

PREGNANCY HISTORY

Total number of pregnancies_____
Number of: Deliveries____Living children____Ages_____
live births____ premature births____
still births____ tubal pregnancies____
miscarrages____ abortions____

Complications of delivery_____
Complications with abortion_____

CONTRACEPTION HISTORY

Have you ever been sexually active?____yes____no. If yes, age at initial incident____
Are you currently sexually active?____yes____no. If yes, frequency of intercourse____
Concerns:_____
Pain with intercourse____yes____no
Bleeding after intercourse____yes____no
Current contraceptive method_____
Contraceptive used in the past: condoms____ foam____ diaphram____
IUD: type_____ length of use_____
oral contraceptive: type_____total time used_____
natural family planning____, withdrawal____
Method desire now?_____
Do you do douche?_____how often?_____solutions used_____
Is this your first pelvic examination?____yes____no
Date of last pelvic examination and Pap smear_____
Where was it done?_____ Pap results_____

SOCIAL HISTORY

Do you smoke cigarettes?_____packs per day_____
Do you drink alcoholic beverages daily?____yes____no