

(Please Print in Black Ink)

# CONFIDENTIAL PATIENT INFORMATION ELIZABETHTOWN PHYSICIANS FOR WOMEN, PSC

1115 Woodland Dr.  
Elizabethtown KY 42701  
270-769-5963  
www.etownobgyn.com

(last) (first) (middle) Maiden Birthday

Name \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone( ) \_\_\_\_\_ Hm. Phone( ) \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ (Marital Status) M W S D

E-mail Address \_\_\_\_\_ S.S. No \_\_\_\_\_

Religion \_\_\_\_\_ Race \_\_\_\_\_ Referred By \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Wk. Phone( ) \_\_\_\_\_ Yrs. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employment Status:  Full Time  Part Time  Unemployed  Disabled  Self-Employed  Retired Date of retirement \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Policy Holders Employer Name/Address \_\_\_\_\_ Wk. Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Effective Date for this ins. \_\_\_\_\_

2<sup>nd</sup> Insurance Co. Name \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Policy Holders Employer Name/Address \_\_\_\_\_ Wk. Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Effective Date for this ins. \_\_\_\_\_

Spouse's Name \_\_\_\_\_ DOB \_\_\_\_\_ S.S. No. \_\_\_\_\_

Emergency Contact (Other than Spouse) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Please list all drug allergies \_\_\_\_\_

Other Physicians managing your care: \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone# \_\_\_\_\_

Does your insurance plan cover annual preventive wellness exams  yes  no  unsure

Please check one, are you here for a  Yearly Exam  Problem Visit  Pregnancy

We will fill out up to 1 form for a Hospitalization and/or Surgical Procedure at no cost to you. There will be a \$25.00 charge to complete each additional form and/or forms for routine office visits.

As part of medical procedures or tests, I understand that I will be tested for human immunodeficiency virus (HIV) infection, hepatitis, or any other blood-borne infectious disease if my doctor orders such testing for diagnosis purposes, and I consent to all such testing.

**I herby authorize and direct** my insurance carrier to pay directly to the undersigned physician any benefits due my insurance plan(s) authorize the undersigned physician to release any information acquired in the course of my care to release any information requested by my insurance company or its representative.

**I hereby assign** to Elizabethtown Physicians for Women all money to which I am entitled for medical and/or surgical expenses relative the service rendered, but not to exceed my indebtedness to Elizabethtown Physicians for Women.

**I understand** that I am financially responsible to Elizabethtown Physicians for Women for charges not covered by this assignment. The undersigned waives all rights of exemption under the laws of the state.

**I agree** to pay all collection costs of no less than 30% and court costs and reasonable attorney fees if I fail to promptly pay this account when due and turned over to collection service.

**I consent** to treatment as necessary or desirable to the care of the patient first named above. I acknowledge full responsibility to pay for this treatment. Payment is due at the time of service, as are co-payments and deductibles, unless prior arrangements are made. If we do not receive payment from your insurance company within 30 days, we ask that you contact them to get your bill paid.

**ALL CHARGES WILL BECOME THE PATIENTS RESPONSIBILITY IF YOUR INSURANCE HAS NOT PAID WITHIN 60 DAYS.**

Signed (Patient, Parent or Agent) \_\_\_\_\_ Date \_\_\_\_\_

## OPERATIONS / HOSPITALIZATIONS

OPERATION	DATE	HOSPITAL / DOCTOR

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

## OBSTETRIC HISTORY

Number				Number				Number			
Pregnancies				Live Births				Miscarriages			
Premature Birth(<37 weeks)				Living Children				Abortions			
NO.	Date of Birth	Wt. at birth	Baby's Sex	Weeks Pregnant	Type of Delivery	Complications?					
1			Male / Female		Vaginal / C-section						
2			Male / Female		Vaginal / C-section						
3			Male / Female		Vaginal / C-section						
4			Male / Female		Vaginal / C-section						

## PERSONAL PAST HISTORY OF ILLNESS

Major Illness	YES	NO	Major Illness	YES	NO	Major Illness	YES	NO
Asthma			Stroke			Blood Transfusions		
Pneumonia / Lung Disease			Rheumatic Fever			Seizures / Epilepsy		
Kidney Infection / Stones			Blood Clots in Lungs / Legs			Bowel Problems		
Tuberculosis			Eating Disorder			Glaucoma		
STD's			Lupus			Cataracts		
HPV			Cancer			Arthritis, Joints, Back Problem		
HIV / AID's			Ulcer, Reflux, Hernia			Irritable bowel / Spastic Colon		
Heart Trouble			Depression / Anxiety			Hepatitis / Liver Disease		
Diabetes			Anemia			Thyroid Disease		
High Blood Pressure			Abnormal Pap Smears			Elevated Cholesterol		
Physicians Notes								

## SOCIAL HISTORY

	YES	NO		YES	NO
Do you smoke? Packs per day ___ Year(s) ___	<input type="checkbox"/>	<input type="checkbox"/>	Seat belt use	<input type="checkbox"/>	<input type="checkbox"/>
Ex-smoker? Packs per day ___ Year(s) ___	<input type="checkbox"/>	<input type="checkbox"/>	Regular Exercise	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol: Drinks per week ___ Year(s) ___	<input type="checkbox"/>	<input type="checkbox"/>	Take calcium supplement	<input type="checkbox"/>	<input type="checkbox"/>
Recreation, drug use	<input type="checkbox"/>	<input type="checkbox"/>	Sexually abused or hurt by someone	<input type="checkbox"/>	<input type="checkbox"/>
Age of first sexual intercourse _____			Number of sexual partners during your lifetime _____		

## FAMILY HISTORY

	YES	NO	Physicians Notes		YES	NO	Physicians Notes
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clots in lungs/legs	<input type="checkbox"/>	<input type="checkbox"/>		Misc. cancer	<input type="checkbox"/>	<input type="checkbox"/>	

## REVIEW OF SYSTEMS

Mark (X) all that apply If no marks system is neg.

<p><b>Constitutional</b></p> <p>Recent weight loss/gain <input type="checkbox"/></p> <p>Fatigue <input type="checkbox"/></p> <p><b>Eyes</b></p> <p>Vision Change <input type="checkbox"/></p> <p>Contacts / Glasses <input type="checkbox"/></p> <p><b>Ears, Nose, Throat</b></p> <p>Hearing <input type="checkbox"/></p> <p>Sinus problems <input type="checkbox"/></p> <p>Mouth Sores <input type="checkbox"/></p> <p><b>Cardiovascular</b></p> <p>Chest Pain <input type="checkbox"/></p> <p>Difficulty breathing with exertion <input type="checkbox"/></p> <p>Swelling of Feet / legs <input type="checkbox"/></p> <p>Rapid or irregular heartbeat <input type="checkbox"/></p> <p>Heart murmur <input type="checkbox"/></p> <p>Varicose veins <input type="checkbox"/></p> <p><b>Respiratory</b></p> <p>Wheezing <input type="checkbox"/></p> <p>Spitting up blood <input type="checkbox"/></p> <p>Shortness of breath <input type="checkbox"/></p> <p>Chronic cough <input type="checkbox"/></p> <p><b>Gastrointestinal</b></p> <p>Frequent Diarrhea <input type="checkbox"/></p> <p>Bloody stool / Rectal bleeding <input type="checkbox"/></p> <p>Nausea /Vomiting <input type="checkbox"/></p> <p>Constipation <input type="checkbox"/></p> <p>Involuntary loss of stool <input type="checkbox"/></p>	<p><b>Genitourinary</b></p> <p>Abnormal Pap Smear <input type="checkbox"/></p> <p>Abnormal bleeding <input type="checkbox"/></p> <p>Painful periods <input type="checkbox"/></p> <p>Painful intercourse <input type="checkbox"/></p> <p>Abnormal vaginal discharge <input type="checkbox"/></p> <p>Difficulty becoming pregnant <input type="checkbox"/></p> <p>PMS <input type="checkbox"/></p> <p>DES exposure <input type="checkbox"/></p> <p>Blood in urine <input type="checkbox"/></p> <p>Pain with urination <input type="checkbox"/></p> <p>Frequent <input type="checkbox"/></p> <p>Involuntary loss of urine <input type="checkbox"/></p> <p>Urine Loss with coughing <input type="checkbox"/></p> <p>Urine loss if can't go quickly <input type="checkbox"/></p> <p><b>Musculo Skeletal</b></p> <p>Muscle weakness <input type="checkbox"/></p> <p>Muscle or joint pain <input type="checkbox"/></p> <p><b>Skin</b></p> <p>Unwanted hair <input type="checkbox"/></p> <p>Black or enlarging moles <input type="checkbox"/></p>	<p><b>Breasts</b></p> <p>Pain in breasts <input type="checkbox"/></p> <p>Nipple Discharge <input type="checkbox"/></p> <p>Lumps <input type="checkbox"/></p> <p><b>Neurologic</b></p> <p>Dizziness <input type="checkbox"/></p> <p>Seizures <input type="checkbox"/></p> <p>Numbness <input type="checkbox"/></p> <p>Frequent severe headaches <input type="checkbox"/></p> <p>Migraines <input type="checkbox"/></p> <p><b>Psychiatric</b></p> <p>Depression or crying episodes <input type="checkbox"/></p> <p>Severe anxiety <input type="checkbox"/></p> <p>Sleep problems <input type="checkbox"/></p> <p>Panic attacks <input type="checkbox"/></p> <p><b>Endocrine</b></p> <p>Hair loss <input type="checkbox"/></p> <p>Heat / Cold intolerance <input type="checkbox"/></p> <p>Abnormal thirst <input type="checkbox"/></p> <p>Hot flashes <input type="checkbox"/></p> <p><b>Hematologic / Lymphatic</b></p> <p>Cuts do not stop bleeding <input type="checkbox"/></p> <p>Enlarged lymph nodes <input type="checkbox"/></p> <p><b>Allergic / immunology</b></p> <p>Medication allergies <input type="checkbox"/></p>	
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**Physicians Notes**

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Are your immunizations up to date? YES NO \_\_\_\_\_

Do you do self breast exams? Never Sometimes Monthly

If using birth control, which method? Birth control pills Foam Condoms Depo-Provera

Birth control patch Birth control ring Nexplanon IUD Withdrawal Vasectomy Tubal Ligation

If age 50 or older, have you had:

A. Sigmoidoscopy or colonoscopy in past 5 years Yes No

B. Bone Density Test (Test for Osteoporosis) Yes No