Patient's Name ______________________________ **DOB:** ______________

Question	Answer
How old were you first started your period?	
How many days in between periods?	
How long does your period last?	
How many pads or tampons do you change in a day when you have a period?	
Date of the first day of your most recent period.	
Have you ever had any of the following sexually transmitted diseases? If yes, please circle: HIV HEPATITIS B HEPATITIS C GONORRHEA HERPES CHLAMYDIA VENEREAL WARTS TRICHOMONAS HPV (Human Papilloma Virus)	
Have you ever had surgery on your cervix? Please list.	
Have you ever had surgery on your uterus, tubes, or ovaries? Please list.	
Have you ever had any other gynecologic surgery? Please list.	
Have you ever had an ectopic (tubal) pregnancy?	
What was your most recent birth control method?	
How many total pregnancies have you had?	
How many children do you have?	
How many miscarriages have you had?	
How many abortions have you had	

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Patient's Name ______________________ DOB: ____________

PATIENT MEDICAL HISTORY

CONDITIONS	YES	NO	SPECIFY (If applicable)
Chest Pain			
Shortness of Breath			
Hypertension (high blood pressure)			
Hyperlipidemia (high cholesterol)			
Myocardial Infarction (heart attack)			
Congestive Heart Failure			
Abnormal Heart Beat			
Lightheadedness/Passing Out			
Enlarged Heart			
Heart Murmur			
Rheumatic Fever			
Stroke			
Blood Clots			
Peripheral Vascular Disease			
Swelling or Aching in Legs			
CONDITION	**YES**	**NO**	**SPECIFY (If applicable)**
Other Vascular			
Excessive Fatigue			
Diabetes			
Gastrointestinal Problems			
Orthopedic Problems			
Asthma			
Emphysema			
Other Respiratory Problems			
Headaches			
OB/GYN Problems			
Thyroid			
Urinary/Genitourinary			
Hematological			
Immunological			
Psychological/Psychiatric			
Neurological Problems			
Other			

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Patient's Name ______________________________ **DOB:** ______________

ABOUT YOU

Have you ever smoked? __________ If so, how many packs per day _____ for _____ years.

Do you exercise? __________ How often ______________________________

Do you drink alcohol? __________ How much? ____________________ per month

Do you drink coffee? __________ Ho much? ____________________ per month

Do you use recreational drugs? __________ How much? ____________________ per month

PAST SURGERY AND HOSPITALIZATION

Surgery/Hospitalization	Reason	Date (mm/dd/yy)

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Patient's Name ______________________________ **DOB:** ______________

ABOUT YOU

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Do you drink alcohol? __________ How much? ____________________ per month

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PAST SURGERY AND HOSPITALIZATION

Surgery/Hospitalization	Reason	Date (mm/dd/yy)

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Patient's Name ______________________________ DOB: ________________

FAMILY HISTORY

Relative	Age (or age at death)	History of Cancer: Ovarian Uterine Cervical Breast (Please Specify)	History of Hearth Disease	History of High Blood Pressure	History of Heart Attack	History of Diabetes	History of Stroke	If deceased, list cause of death
Father								
Mother								
Sister								
Sister								
Brother								
Brother								
Maternal Grandfather (Mother's side)								
Maternal Grandfather (Mother's side)								
Paternal Grandfather (Father's side)								
Paternal Grandfather (Father's side)								
Other (Specify)								
Other (Specify)								

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Patient's Name ______________________ DOB: ____________

CURRENT MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS AND HERBS

Medication	Dosage (Mgs)	Times per Day

ALLERGIES and REACTIONS

____

____

Do you need a nurse/chaperone present at the time of the exam? Yes or No

LIFETIME INSURANCE AUTHORIZATION

I, ____________________, authorize the release of any medical information necessary to process my insurance claims. I request that all payments be made on my behalf and that all benefits be assigned for physician services to Dr. Lisa P. Otey. I, ____________________, authorize this request to apply to all services provided after the date below. I understand that I am responsible for payment of any balance not paid by my insurance company, as outlined in my schedule of benefits and as applicable under the law.

____

Patient Signature Patient's Name Date

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Patient's Name ______________________________ **DOB:** ______________

EMERGENCY CONTACT INFORMATION

Spouse/Significant Other Contact Information

Spouse Name: ______________________________

Spouse Address (if different): ______________________________

City: ______________ State/Province: ______________ Zip Code: ______________

Country (if outside US): ______________________________

Home Phone: ______________ Cell Phone: ______________

Spouse Occupation: ______________________________

Spouse Employer: ______________ Work Phone: ______________

Other Relative Emergency Contact Information

Name of Nearest Relative: ______________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________

Work Phone: ______________________________

IN CASE OF EMERGENCY, I HEREBY AUTHORIZE YOU TO CONTACT THE FOLLOWING EMERGENCY CONTACT(S):

Spouse/Significant Other: ______________________________

Other Nearest Relative: ______________________________

PLEASE BE AWARE, IN CASE OF EMERGENCY I HAVE COMPLETED THE FOLLOWING DOCUMENTS THAT I WILL PROVIDE TO THIS PHYSICIAN'S OFFICE WITHIN 10 DAYS OF SIGNATURE BELOW. I AM AWARE THAT MY REQUESTS CAN NOT BE FOLLOWED UNLESS APPROPRIATELY SIGNED LEGAL DOCUMENTS ARE MAINTAINED IN THIS CHART OR PROVIDED AT THE TIME OF EMERGENCY.

Living Will: ______________ **Do Not Resuscitate (DNR):** ______________

Patient Signature: ______________ **Witness:** ______________
Patient Name: ______________ **Witness Name:** ______________
Date: ______________

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