
Jonathan O. Nwanagu, M.D.

Board Certified - American Board of Obstetrics and Gynecology

# PATIENT REGISTRATION

(COMPLETE ALL ITEMS THOROUGHLY)

## PATIENT INFORMATION

PATIENT NAME _____
(LAST) (FIRST) (MI)

HOME _____ MOBILE _____ EMAIL _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP) (COUNTY)

DOB _____ AGE _____ SS# _____ MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ PHONE _____

NAME OF SPOUSE _____ MOBILE _____

SPOUSE'S EMPLOYER _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

WHO REFERRED YOU TO US? MD/ FAMILY/ FRIEND / INTERNET / OTHER _____

PRIMARY CARE PHYSCIAN _____ PHONE _____

PREFERRED PHARMACY _____ PHONE _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

## RESPONSIBLE PARTY

NAME _____ RELATIONSHIP _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ WORK PHONE _____

EMPLOYER _____ ADDRESS _____

**SIGNATURE** _____ **DATE** _____

Sandhills
OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D. Board Certified - American Board of Obstetrics and Gynecology

## INSURANCE INFORMATION

| PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|
| Insurance Company _____ | Insurance Company _____ |
| Policy Holder's Name _____ | Policy Holder's Name _____ |
| SS# _____ DOB_____ Sex_____ | SS# _____ DOB_____ Sex_____ |
| Policy# _____ Grp# _____ | Policy# _____ Grp# _____ |
| Employer/Group Name _____ | Employer/Group Name _____ |

## PAYMENT POLICY AGREEMENT
**(Please Initial)**

_____1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we are in network with or contracted with, payment in full is expected at each visit. All co-payments, deductibles, and co-insurance is due at time of service. Please be aware that some services you receive may not be covered by your insurance carrier. You must pay for these services at the time of your visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductible, and co-insurance from patients can be considered fraud.

_____2. **Proof Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a scan of your driver's li cense and current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim or be asked to re-schedule. **Please contact your insurance company to be sure your plan's requirements have been met and that all referral and prior authorizations are in place before seeking care.**

_____3. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes. If your insurance company does not pay your claim in 60 days, the balance will be automatically billed to you. **We do not re-file claims.**

_____4. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating you have 14 days to pay your account in full. Partial payments will not be accepted unless prior financial arrangements were made. If a balance remains unpaid, we may refer your account to a collection agency. Once the account has been referred, finance charges of 1.5 % per month (18% per year) will be added to invoices. We may contact you by telephone at any number associated with your account. We may also contact you by sending text messages, emails using any email you have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

_____**5. Discharged patients**. If you fail to fulfill your financial obligations, you will be discharged from the practice. You will be notified by certified mail and will have 30 days to find an alternative medical care. During that period, the doctor will only see you for emergency care.

_____**6. Laboratory Fees.** Fees for services (pap smear, culture or biopsy, bloodwork) performed by an outside laboratory are your responsibility. If you should have any questions regarding those fees, please call the telephone number directly on the invoice.

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Our practice is committed to providing the best treatment to our patients. Our fees are set according to the usual and customary fees for our specialty and area. Thank you for understanding our payment policy agreement. If at any time you have any questions or concerns regarding your care, we are here for you.

I certify that all the information provided is correct. I hereby authorize direct payment of surgical/medical benefits to Sandhills OB/GYN for services rendered by them in person or under their supervision. It is my responsibility to notify the insurance company prior to admission if precertification is necessary. I understand that **I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.** I further understand that if my account is turned over to a collection agency, finance charges of 1.5 % per month (18% per year) will be added to invoices.

_____
Patient Name (Print)

_____ _____
Patient Signature or Responsible Party Date

## Consent for Treatment

Our Notice of Privacy Practices provides information about how we may us and disclose protected health information (PHI) about you. You have read, understand and have been provided with a copy our notice of privacy practices. As provided in our notice, the terms of our notice may change, If we change our notice, you may obtain a revised copy by submitting your request in writing or by reviewing the current copy in our waiting room. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. **We are not required to agree to this restriction, but if we do, we are bound by our agreement.**

I hereby agree and give consent to the treating physician and employees of this office and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examination and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

**For HOSPITAL EMERGENCIES, ADMISSIONS, AND THE DELIVERY OF BABIES, you must present to PRISMA BAPTIST HOSPITAL, located at Taylor and Marion in downtown Columbia to order to be seen by Dr. Nwanagu.**

_____
Signature of Patient/Legal Guardian Relationship to Patient Date

_____ _____
Patient/Legal Guardian Name Printed Witness Signature Date

1333 Taylor Street, Suite 3J - Columbia, S.C. 29201 - (P.O. Box 7481 - Columbia, S.C. 29202) - Tel. (803) 727-1935 - Fax (803) 254-0070

Sandhills
OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D. Board Certified - American Board of Obstetrics and Gynecology

## PATIENT HIPAA CONSENT FORM

This authorization form permits Dr. Jonathan Nwanagu, Sandhills OB/GYN, Associates, P.A. (P.O Box 7481, Columbia, SC 29202) to use or disclose protected health information listed in Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name: _____ Birth Date: _____

| **Receiving Entity: Please indicate those entities or persons you wish to receive described information about you.** | **Description of information to be given corresponding Entity or Person.** |
|---|---|
| Voicemail # | Appointment Time<br>Results of lab test or x-rays<br>Other |
| Spouse (Provide Name) | Financial Information<br>Medical Information – please list |
| Parent (Provide Name) | Financial Information<br>Medical Information – please list |
| Other (Provide Name) | Financial Information<br>Medical Information – please list |

**Purpose**

The purpose of this authorization is to meet the patient's request for information disclosures and uses. **Expiration date or event:** This authorization shall be enforced until revoked by the patient or _____

**By signing this form, you consent to the use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You authorize Sandhills OB/GYN to release your personal health information as directed above:**

_____

Signature of Patient/Legal Guardian Relationship to Patient Date

_____ _____

Patient/Legal Guardian Name Printed Witness Signature Date

Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Courtney M. Hillen, MSN, CNM

# Authorization for Release of Protected Health Information

Patient's Name at the time of treatment: _____

Patient's Address: _____

Date of Birth: _____ Social Security Number: _____

Date(s) of treatment: _____

Purpose of release: _____

**I authorize to release my health records to:**

Clinic Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

**I authorize to release my health records from:**

Clinic Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

_____Mail Record _____ Patient Pickup _____ Send via Fax

Information to be released: (Please check all that apply.)

___ Entire Medical Record
___ Physician Notes
___ Office Notes
___ Pathology Reports
___ Cytology Reports
___ Mammography Films
___ Laboratory Report
___ EKG/Cardiovascular
___ Pulmonary Function Test
___ Radiology Reports
___ Operative Report
___ Other _____

1) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2) I understand that if this person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of the form.
4) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5) I understand the charge for obtaining the requested information will be $.65 per page for the first 30 pages, $.50 per page for all additional pages and a $15.00 clerical fee.
6) I understand that this authorization will expire 90 days after signed unless an earlier date is specified here _____.

_____ _____
Signature of patient or authorized person Date

_____
Relationship/Reason patient is unable to sign

Verification Completed by _____

FOR OFFICE USE ONLY

☐ NEW PATIENT
☐ ESTABLISHED PATIENT
☐ CONSULTATION
☐ REPORT SENT. / /

# PATIENT INTAKE HISTORY

| | | | |
|---|---|---|---|
| PATIENT NAME: | BIRTH DATE: / / | ID NO.: | DATE: / / |
| ADDRESS: | | | |
| CITY: | STATE/ZIP: | | |
| HOME TELEPHONE: ( ) | WORK TELEPHONE: ( ) | | |
| EMPLOYER: | INSURANCE: | POLICY NO.: | |
| NAME YOU WOULD LIKE US TO USE: | PRIMARY LANGUAGE: | | |
| NAME OF SPOUSE/PARTNER: | EMERGENCY CONTACT: | | |
| | RELATIONSHIP: | | |
| | HOME TELEPHONE: ( ) | WORK TELEPHONE: ( ) | |
| REFERRED BY: | | | |
| WHY HAVE YOU COME TO THE OFFICE TODAY? | | | |
| IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A ☐ PRIMARY CARE VISIT OR ☐ GYNECOLOGY ONLY | | | |
| IS THIS A NEW PROBLEM? | | | |
| PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED | | | |
| | | | |
| | | | |
| | | | |

**If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.**

## GYNECOLOGIC HISTORY

| | PHYSICIAN'S NOTES |
|---|---|
| LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / / | |
| AGE PERIODS BEGAN: | |
| LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING): | |
| NUMBER OF DAYS BETWEEN PERIODS: | |
| ANY RECENT CHANGES IN PERIODS? | |
| ARE YOU CURRENTLY SEXUALLY ACTIVE? | |
| HAVE YOU EVER HAD SEX? | |
| NUMBER OF SEXUAL PARTNERS (LIFETIME): | |
| SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH | |
| PRESENT METHOD OF BIRTH CONTROL: | |
| HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS? | |
| IF YES, FOR HOW LONG? | |
| WHEN WAS YOUR LAST PAP TEST? | |
| WHAT WAS THE RESULT? | |
| HAVE YOU EVER HAD AN ABNORMAL PAP TEST? | |
| DO YOU DO BREAST SELF-EXAMINATIONS? | |
| HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)? | |

# PATIENT INTAKE HISTORY *(Continued)*

| PATIENT NAME: | BIRTH DATE: / / | ID NO.: | DATE: / / |
|---|---|---|---|

## OBSTETRIC HISTORY

| | NUMBER | | NUMBER | | NUMBER |
|---|---|---|---|---|---|
| PREGNANCIES | | ABORTIONS | | MISCARRIAGES | |
| PREMATURE BIRTHS (<37 WEEKS) | | LIVE BIRTHS | | LIVING CHILDREN | |

| NO. | BIRTH DATE | WEIGHT AT BIRTH | BABY'S SEX | WEEKS PREGNANT | TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.) | PHYSICIAN'S NOTES |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

## CURRENT MEDICATIONS

**(Including hormones, vitamins, herbs, nonprescription medications)**

| DRUG NAME | DOSAGE | WHO PRESCRIBED | DRUG NAME | DOSAGE | WHO PRESCRIBED |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## FAMILY HISTORY

| | | | |
|---|---|---|---|
| MOTHER: ☐ LIVING ☐ DECEASED–CAUSE: | AGE: | FATHER: ☐ LIVING ☐ DECEASED–CAUSE: | AGE: |
| SIBLINGS: NUMBER LIVING: | NUMBER DECEASED: | CAUSE(S)/AGE(S): | |
| CHILDREN: NUMBER LIVING: | NUMBER DECEASED: | CAUSE(S)/AGE(S): | |

| ILLNESS | YES | WHICH RELATIVE(S) AND AGE OF ONSET | PHYSICIAN'S NOTES |
|---|---|---|---|
| DIABETES | ☐ | | |
| STROKE | ☐ | | |
| HEART DISEASE | ☐ | | |
| BLOOD CLOTS IN LUNGS OR LEGS | ☐ | | |
| HIGH BLOOD PRESSURE | ☐ | | |
| HIGH CHOLESTEROL | ☐ | | |
| OSTEOPOROSIS (WEAK BONES) | ☐ | | |
| HEPATITIS | ☐ | | |
| HIV/AIDS | ☐ | | |
| TUBERCULOSIS | ☐ | | |
| BIRTH DEFECTS | ☐ | | |
| ALCOHOL OR DRUG PROBLEMS | ☐ | | |
| BREAST CANCER | ☐ | | |
| COLON CANCER | ☐ | | |
| OVARIAN CANCER | ☐ | | |
| UTERINE CANCER | ☐ | | |
| MENTAL ILLNESS/DEPRESSION | ☐ | | |
| ALZHEIMER'S DISEASE | ☐ | | |
| OTHER | ☐ | | |

# PATIENT INTAKE HISTORY *(Continued)*

| PATIENT NAME: | BIRTH DATE: / / | ID NO.: | DATE: / / |
|---|---|---|---|

## SOCIAL HISTORY

| | YES | NO | PHYSICIAN'S NOTES |
|---|---|---|---|
| EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS: | ☐ | ☐ | |
| ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK: | ☐ | ☐ | |
| DRUG USE | ☐ | ☐ | |
| SEAT BELT USE | ☐ | ☐ | |
| REGULAR EXERCISE: HOW LONG AND HOW OFTEN? | ☐ | ☐ | |
| DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS: DAILY INTAKE: | ☐ | ☐ | |
| HEALTH HAZARDS AT HOME OR WORK? | ☐ | ☐ | |
| HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE? | ☐ | ☐ | |
| DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)? | ☐ | ☐ | |
| ARE YOU AN ORGAN DONOR? | ☐ | ☐ | |

## PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL

MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

NUMBER OF LIVING CHILDREN:

NUMBER OF PEOPLE IN HOUSEHOLD:

SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER

CURRENT OR MOST RECENT JOB:

TRAVEL OUTSIDE THE UNITED STATES? LOCATION(S):

## PERSONAL PAST HISTORY OF ILLNESSES

| MAJOR ILLNESSES | YES (DATE) | NO | NOT SURE | PHYSICIAN'S NOTES |
|---|---|---|---|---|
| ASTHMA | | | | |
| PNEUMONIA/LUNG DISEASE | | | | |
| KIDNEY INFECTIONS/STONES | | | | |
| TUBERCULOSIS | | | | |
| FIBROIDS | | | | |
| SEXUALLY TRANSMITTED DISEASE/CHLAMYDIA | | | | |
| INFERTILITY | | | | |
| HIV/AIDS | | | | |
| HEART ATTACK/DISEASE | | | | |
| DIABETES | | | | |
| HIGH BLOOD PRESSURE | | | | |
| STROKE | | | | |
| RHEUMATIC FEVER | | | | |
| BLOOD CLOTS IN LUNGS OR LEGS | | | | |
| EATING DISORDERS | | | | |
| AUTOIMMUNE DISEASE (LUPUS) | | | | |
| CHICKENPOX | | | | |
| CANCER | | | | |
| REFLUX/HIATAL HERNIA/ULCERS | | | | |
| DEPRESSION/ANXIETY | | | | |
| ANEMIA | | | | |
| BLOOD TRANSFUSIONS | | | | |
| SEIZURES/CONVULSIONS/EPILEPSY | | | | |
| BOWEL PROBLEMS | | | | |
| GLAUCOMA | | | | |
| CATARACTS | | | | |
| ARTHRITIS/JOINT PAIN/BACK PROBLEMS | | | | |
| BROKEN BONES | | | | |
| HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE | | | | |
| THYROID DISEASE | | | | |

# PATIENT INTAKE HISTORY *(Continued)*

| PATIENT NAME: | BIRTH DATE: / / | ID NO.: | DATE: / / |
|---|---|---|---|

## PERSONAL PAST HISTORY OF ILLNESSES *(Continued)*

| MAJOR ILLNESSES | YES (DATE) | NO | NOT SURE | PHYSICIAN'S NOTES |
|---|---|---|---|---|
| GALLBLADDER DISEASE | | | | |
| HEADACHES | | | | |
| DES EXPOSURE | | | | |
| INFERTILITY | | | | |
| BLEEDING DISORDERS | | | | |
| OTHER | | | | |
| | | | | |
| | | | | |
| | | | | |

## OPERATIONS/HOSPITALIZATIONS

| REASON | DATE | HOSPITAL |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## INJURIES/ILLNESSES

| TYPE | DATE | TYPE | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## IMMUNIZATIONS/TEST

| | DATE | | DATE |
|---|---|---|---|
| TETANUS-DIPHTHERIA BOOSTER | | INFLUENZA VACCINE (FLU SHOT) | |
| HEPATITIS A VACCINE | | HEPATITIS B VACCINE | |
| VARICELLA (CHICKENPOX) VACCINE | | PNEUMOCOCCAL (PNEUMONIA) VACCINE | |
| MEASLES-MUMPS-RUBELLA (MMR) VACCINE | | TUBERCULOSIS (TB) SKIN TEST. RESULT: | |

| PHYSICIAN'S NOTES: |
|---|
| |
| |
| |
| |
| |

## REVIEW OF SYSTEMS

**Please check (x) if any of the following symptoms apply to you now or since adulthood**

| | NOW | PAST | NOT SURE | PHYSICIAN'S NOTES |
|---|---|---|---|---|
| **1. CONSTITUTIONAL** | | | | |
| WEIGHT LOSS | ☐ | ☐ | ☐ | |
| WEIGHT GAIN | ☐ | ☐ | ☐ | |
| FEVER | ☐ | ☐ | ☐ | |
| FATIGUE | ☐ | ☐ | ☐ | |
| CHANGE IN HEIGHT | ☐ | ☐ | ☐ | |

# PATIENT INTAKE HISTORY *(Continued)*

| PATIENT NAME: | BIRTH DATE: / / | ID NO.: | DATE: / / |
|---|---|---|---|

## REVIEW OF SYSTEMS *(Continued)*

| | NOW | PAST | NOT SURE | PHYSICIAN'S NOTES |
|---|---|---|---|---|
| **2. EYES** | | | | |
| DOUBLE VISION | ☐ | ☐ | ☐ | |
| SPOTS BEFORE EYES | ☐ | ☐ | ☐ | |
| VISION CHANGES | ☐ | ☐ | ☐ | |
| GLASSES/CONTACTS | ☐ | ☐ | ☐ | |
| **3. EAR, NOSE, AND THROAT** | | | | |
| EARACHES | ☐ | ☐ | ☐ | |
| RINGING IN EARS | ☐ | ☐ | ☐ | |
| HEARING PROBLEMS | ☐ | ☐ | ☐ | |
| SINUS PROBLEMS | ☐ | ☐ | ☐ | |
| SORE THROAT | ☐ | ☐ | ☐ | |
| MOUTH SORES | ☐ | ☐ | ☐ | |
| DENTAL PROBLEMS | ☐ | ☐ | ☐ | |
| **4. CARDIOVASCULAR** | | | | |
| CHEST PAIN OR PRESSURE | ☐ | ☐ | ☐ | |
| DIFFICULTY BREATHING ON EXERTION | ☐ | ☐ | ☐ | |
| SWELLING OF LEGS | ☐ | ☐ | ☐ | |
| RAPID OR IRREGULAR HEARTBEAT | ☐ | ☐ | ☐ | |
| **5. RESPIRATORY** | | | | |
| PAINFUL BREATHING | ☐ | ☐ | ☐ | |
| WHEEZING | ☐ | ☐ | ☐ | |
| SPITTING UP BLOOD | ☐ | ☐ | ☐ | |
| SHORTNESS OF BREATH | ☐ | ☐ | ☐ | |
| CHRONIC COUGH | ☐ | ☐ | ☐ | |
| **6. GASTROINTESTINAL** | | | | |
| FREQUENT DIARRHEA | ☐ | ☐ | ☐ | |
| BLOODY STOOL | ☐ | ☐ | ☐ | |
| NAUSEA/VOMITING/INDIGESTION | ☐ | ☐ | ☐ | |
| CONSTIPATION | ☐ | ☐ | ☐ | |
| INVOLUNTARY LOSS OF GAS OR STOOL | ☐ | ☐ | ☐ | |
| **7. GENITOURINARY** | | | | |
| BLOOD IN URINE | ☐ | ☐ | ☐ | |
| PAIN WITH URINATION | ☐ | ☐ | ☐ | |
| STRONG URGENCY TO URINATE | ☐ | ☐ | ☐ | |
| FREQUENT URINATION | ☐ | ☐ | ☐ | |
| INCOMPLETE EMPTYING | ☐ | ☐ | ☐ | |
| INVOLUNTARY/UNINTENDED URINE LOSS | ☐ | ☐ | ☐ | |
| URINE LOSS WHEN COUGHING OR LIFTING | ☐ | ☐ | ☐ | |
| ABNORMAL BLEEDING | ☐ | ☐ | ☐ | |
| PAINFUL PERIODS | ☐ | ☐ | ☐ | |
| PREMENSTRUAL SYNDROME (PMS) | ☐ | ☐ | ☐ | |
| PAINFUL INTERCOURSE | ☐ | ☐ | ☐ | |
| ABNORMAL VAGINAL DISCHARGE | ☐ | ☐ | ☐ | |
| **8. MUSCULOSKELETAL** | | | | |
| MUSCLE WEAKNESS | ☐ | ☐ | ☐ | |

# PATIENT INTAKE HISTORY *(Continued)*

| PATIENT NAME: | BIRTH DATE: / / | ID NO: | DATE: / / |
|---|---|---|---|

## REVIEW OF SYSTEMS *(Continued)*

| | NOW | PAST | NOT SURE | PHYSICIAN'S NOTES |
|---|---|---|---|---|
| **8. MUSCULOSKELETAL** *(Continued)* | | | | |
| MUSCLE OR JOINT PAIN | ☐ | ☐ | ☐ | |
| **9a. SKIN** | | | | |
| RASH | ☐ | ☐ | ☐ | |
| SORES | ☐ | ☐ | ☐ | |
| DRY SKIN | ☐ | ☐ | ☐ | |
| MOLES (GROWTH OR CHANGES) | ☐ | ☐ | ☐ | |
| **9b. BREASTS** | | | | |
| PAIN IN BREAST | ☐ | ☐ | ☐ | |
| NIPPLE DISCHARGE | ☐ | ☐ | ☐ | |
| LUMPS | ☐ | ☐ | ☐ | |
| **10. NEUROLOGIC** | | | | |
| DIZZINESS | ☐ | ☐ | ☐ | |
| SEIZURES | ☐ | ☐ | ☐ | |
| NUMBNESS | ☐ | ☐ | ☐ | |
| TROUBLE WALKING | ☐ | ☐ | ☐ | |
| MEMORY PROBLEMS | ☐ | ☐ | ☐ | |
| FREQUENT HEADACHES | ☐ | ☐ | ☐ | |
| **11. PSYCHIATRIC** | | | | |
| DEPRESSION OR FREQUENT CRYING | ☐ | ☐ | ☐ | |
| ANXIETY | ☐ | ☐ | ☐ | |
| **12. ENDOCRINE** | | | | |
| HAIR LOSS | ☐ | ☐ | ☐ | |
| HEAT/COLD INTOLERANCE | ☐ | ☐ | ☐ | |
| ABNORMAL THIRST | ☐ | ☐ | ☐ | |
| HOT FLASHES | ☐ | ☐ | ☐ | |
| **13. HEMATOLOGIC/LYMPHATIC** | | | | |
| FREQUENT BRUISES | ☐ | ☐ | ☐ | |
| CUTS DO NOT STOP BLEEDING | ☐ | ☐ | ☐ | |
| ENLARGED LYMPH NODES (GLANDS) | ☐ | ☐ | ☐ | |
| **14. ALLERGIC/IMMUNOLOGIC** | | | | |
| MEDICATION ALLERGIES | ☐ | ☐ | ☐ | |
| IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION: | | | | |
| LATEX ALLERGY | ☐ | ☐ | ☐ | |
| OTHER ALLERGIES | ☐ | ☐ | ☐ | |
| PLEASE LIST ALLERGY AND TYPE OF REACTION: | | | | |

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE NURSE ☐ PHYSICIAN ☐ OTHER:

SIGNATURE OF PATIENT:

DATE REVIEWED BY PHYSICIAN WITH PATIENT: / / PHYSICIAN SIGNATURE:

**ANNUAL REVIEW OF HISTORY**

| | |
|---|---|
| DATE REVIEWED: / / | PHYSICIAN SIGNATURE: |
| DATE REVIEWED: / / | PHYSICIAN SIGNATURE: |
| DATE REVIEWED: / / | PHYSICIAN SIGNATURE: |
| DATE REVIEWED: / / | PHYSICIAN SIGNATURE: |
| DATE REVIEWED: / / | PHYSICIAN SIGNATURE: |

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