

For Office Staff

Weight _____
Height _____
BP _____

Gyn & Fertility Specialists Initial Patient Information

Name: _____ Date: _____
Occupation: _____ Date of Birth: _____ Age: _____ Marital Status _____
Ethnicity _____ Referred by: _____ Date of last menstrual period _____
Pharmacy Phone for prescriptions: _____

Reason for visit: Routine Physical (pap smear, pelvic exam & breast exam)
 Problem (please describe) _____

Allergies: Please list allergies to medications, and any reaction to each medication

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Family History: Please list any family medical problems and which family member had the problem.

Breast Cancer _____ Colon Cancer _____ Cervical Cancer _____
Ovarian Cancer _____ Uterine Cancer _____ Heart Disease _____
Diabetes _____ Stroke _____ Osteoporosis _____
High Blood Pressure _____ Heart Disease _____
 I do not know my family history I do not have any significant family history

My Past History: Have you ever had any of the following?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Infertility
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Genital Warts	<input type="checkbox"/> Migraines
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pelvic Inflammatory Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Uterine Fibroids

Other medical history (please list): _____

Have you ever had a pap smear? NO YES/When _____

Have you ever had an abnormal pap smear? NO YES/When? _____

What treatment was given? _____

Have you ever had a mammogram? ___ No ___ Yes/When? _____
If yes, was it normal or abnormal? _____

Please list any previous surgeries: _____

Sexual History: Are you currently sexually active? ___ No ___ Yes
Do you use any contraception? _____
Do you have pain, discomfort or other problems with intercourse? ___ No ___ Yes

Social History:
Do you smoke cigarettes? ___ Yes ___ No How many per day? _____
Have you ever smoked cigarettes? ___ Yes ___ No When did you quit? _____
Do you drink alcohol? ___ Yes ___ No How many drinks per day? _____
Do you use street drugs? ___ Yes ___ No
What kind of street drugs? _____
Do you get regular exercise (describe)? _____
Have you been emotionally or physically abused by your partner or someone important to you? _____
Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? _____

Medications: Please list medication that you take regularly
1. _____
2. _____
3. _____

Obstetrical History: Number of pregnancies _____ Number of full term births _____
Number of miscarriages _____ Number of Preterm births _____ Number of Abortions _____
Number of ectopic/tubal pregnancies _____

	First Delivery	Second Delivery	Third Delivery	Fourth Delivery	Fifth Delivery
Date of Delivery					
Gestational age at delivery					
Type of Delivery					
Pregnancy or delivery complications?					
Birth weight?					

GYN & FERTILITY SPECIALISTS

Magdi Hanafi, MD, FACOG, FICS, DOBRCP

Gynecology, Infertility, GYN Syrgery, Tubal Reversal & Laparoscopic Surgery

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www.gynfertility.medem.com mhanagi@aol.com

Date _____ Age _____ Birthday _____ SS# _____

Full Name Miss/Mrs. _____

Address _____ Apt # _____ City _____

State _____ Zip _____ Phone _____ Cell Phone _____

Employer _____ Occupation _____

Buisness phone _____ ext _____ How long employed _____

Husband/Partner/Parent Name _____

Birthday _____ Age _____ SS# _____

Employer _____ How long employed _____

Buisness phone _____ ext _____ Referred by _____

Case of Emergency Name _____ Phone _____

Email address _____

INSURANCE INFORMATION

Name of Insurance Co. #1 _____

Mailing Address _____

Name of Insured _____ ID# _____

Group Name _____ Group# _____

PERSON RESPONSIBLE FOR THE BILL _____

NOTICE: PAYMENT IS EXPECTED AT THE TIME OF SERVICE; WE ACCEPT CASH, CHECK, VISA, MC, AMERICAN EXPRESS, AND DISCOVER CARDS.

All charges are the responsibility of the patient. We are contracted to bill most all insurances. Any copayment or deductible is due at the time of service. It is the patient's responsibility to understand their own insurance coverage. Insurance companies do not guarantee payments over the phone, only a quote of benefits at the time of inquiry. Patients must report any changes of insurance at the time of visit, otherwise any denials to file timely will cause the balance to become patient's responsibility.