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?

_____Asthma	_____Genital Herpes	_____Infertility
_____Breast Cancer	_____Genital Warts	_____Migraines
_____Chlamydia	_____Gonorrhea	_____Mitral Valve Prolapse
_____Blood Clots	_____Heart Disease	_____Osteoporosis
_____Depression	_____Hepatitis	_____Pelvic Inflammatory Disease
_____Diabetes	_____High Blood Pressure	_____Stroke
_____Eating Disorder	_____High Cholesterol	_____Thyroid Disease
_____Endometriosis	_____HIV/AIDS	_____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

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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.