Grand Valley Women's Health Specialists
Community HOSPITAL

PATIENT INFORMATION		
Name:		
Date of Birth:	Age:	Gender: Female
Social Security Number:	Marital Status:	
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
Employer:	Work Phone:	
Physician:		
Preferred Pharmacy:	Location:	
RESPONSIBLE PARTY (IF PATIENT IS UNDER 18 YEARS OLD)		
Name:		
Date of Birth:	Age:	Gender:
Social Security Number:	Marital Status:	
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
Employer:	Work Phone:	
EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		
Address:	Phone:	
Relationship:		
INSURANCE INFORMATION		
Primary Insurance:	Secondary Insurance:	
Certification#:	Certification#:	
Subscriber Name:	Subscriber Name:	
Subscriber DOB:	Subscriber DOB:	
Subscriber Sex: M / F	Subscriber Sex: M / F	

OPTIONAL INFORMATION								
*Race:		Asian		White		American Indian/ Native American		Hispanic / Latino
		Hawaiian / Other Pacific Islander		Black / African American		More than one race		Refuse to answer
*Ethnicity:		Hispanic / Latino		Not Hispanic/ Latino				Refuse to answer
*Preferred Language								

*As part of an effort to improve health care, the US Government requires that we ask these questions.

REASON FOR VISIT:_____

Signature of Patient/Legal Guardian: _____Date:_____

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Health History

Patient: DOB: Age: Gender:

Allergies: List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Allergy	Reaction	Date of Incident

Medications: Please list all of the medication you are taking, including over-the-counter and vitamins.

Medication	Strength	Frequency Taken

Health Maintenance:

Test	Date	Result (Please Circle)	
Complete Physical		Normal	Abnormal
Colonoscopy		Normal	Abnormal
Lipid (Cholesterol)		Normal	Abnormal
Eye Exam		Normal	Abnormal
		Normal	Abnormal
PAP Smear (Women)		Normal	Abnormal
Mammogram (Women)		Normal	Abnormal
Immunization	**Date**	**Immunization**	**Date**
Pneumonia Shot		Flu Shot	
Tetanus		Meningitis	
Gardasil (HPV)		Other Childhood Immunizations up-to-date? Yes No	

Social History: Check all that apply

Tobacco: ____ Current Every Day Smoker _____ Current Some Days Smoker # _____ Packs Per Day _____ Former Smoker _____ Never a Smoker _____ Use Chewing Tobacco			
Alcohol Use:	NO	YES	How much per day?
Drug Use:	NO	YES	How much per day?
Exercise:	NO	YES	What kind of exercise? How often do you exercise?
Marital Status: ___ Single ___ Married ___Separated ____ Divorced ____ Widowed			
Level of School Completed:			

Assignment of Benefits: I hereby assign to GVWHS any insurance or other third party benefits available for health care services provided to me. I understand that GVWHS has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to GVWHS, I agree to forward to the practice all health insurance and other third party payments I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____ Date: _____

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OB/GYN Health History

Name: _____ Date of Birth: _____

Pregnancy History (Including Miscarriages and/or Abortions)

Year	Length of Pregnancy	Childs Gender	Complication

Are you sexually active? YES or NO
Current sexual partner is: Female Male
Current Method of Birth Control Used: _____

Age of First Menstrual Period: _____ Date of Last Menstrual Period: _____
Regular: Yes or No Age of Menopause: _____

Medical History/Surgeries (including year, type of condition and any treatment)
