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
PSA (Men 50-70 y.o.)		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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Patient: **DOB**: **Age**: **Gender**:

Please mark any symptoms you are experiencing that are <u>related to you complaint today</u>.

Allergic/Immunologic		**Ears/Nose/Mouth/Throat**		**Genitourinary**		**Men Only**	
	Frequent Sneezing		Bleeding Gums		Pain with Urinating		Pain/Lump Testicle
	Hives		Difficulty Hearing		Blood in Urine		Penile Itching, Burning or Discharge
	Itching		Dizziness		Difficulty Urinating		
	Runny Nose		Dry Mouth		Incomplete Emptying		Problems Stopping or Starting Urine Stream
	Sinus Pressure		Ear Pain		Urinary Frequency		
Cardiovascular			Frequent Infections		Loss of Urinary Control		Waking to urinate at night
	Chest Pressure / Pain		Frequent Nosebleeds	**Hematologic / Lymphatic**			
	Chest Pain on Exertion		Hoarseness		Easy Bruising / Bleeding		Sexual problems or concerns
	Irregular Heart Beats		Mouth Breathing		Swollen Glands		
	Lightheaded		Mouth Ulcers	**Integumentary (Skin)**			History of Sexually Transmitted Diseases
	Swelling (Edema)		Nose/Sinus Problems		Change in Moles		
	Shortness of Breath When Lying Down		Ringing in Ears		Dry Skin	**Women Only**	
		Endocrine			Eczema		Bleeding Between Periods
	Shortness of Breath When walking		Increased Thirst / Urination		Growth / Lesions		
			Heat / Cold Intolerance		Itching		Heavy Periods
Constitutional		**Gastrointestinal**			Jaundice (Yellow Skin/ Eyes)		Extreme Menstrual Pain
	Exercise Intolerance		Abdominal Pain		**Rash**		
	Fatigue		Black / Tarry Stool	**Respiratory**			Vaginal Itching, Burning or Discharge
	Fever		Blood in Stool		Cough		
	Weight Gain (___ lbs)		Change in Appetite		Cough Up Blood		Waking to Urinate at Night
	Weight Loss (___lbs)		Frequent Indigestion		Shortness of Breath		
	Travel Within 10 Days Where:		Hemorrhoids		Sleep Apnea		Hot Flashes
			Trouble Swallowing		Snoring		Breast Lump
Eyes			Vomiting		Wheezing		Breast Pain
	Dry Eyes		Constipation		Difficulty Breathing		Nipple Discharge
	Eye Irritation		Diarrhea	**Neurological**			No Periods
	Vision Changes		Nausea		Dizziness		Painful Intercourse
Psychiatric		**Musculoskeletal**			Fainting		History of Sexually Transmitted Disease
	Anxiety / Stress		Back Pain		Headache / Migraines		
	Depression		Joint Pain		Memory Loss		
	Do Not Feel Safe in Relationship		Muscle Aches		Numbness		
			Muscle Weakness		Restless Legs		
	Mania				Seizures		
	Sleep Problems				Weakness		

Are you sexually active? YES NO

Current sexual partner is: Female Male

Current Method of Birth Control Used: _____ Women Only:

Women Only: Age of First Menstrual Period: _____ Date of Last Menstrual Period: _____

Age at Menopause: _____ Number of Pregnancies: _____ Live Births: _____

Condition	SELF	Father	Mother	Sibling	Mother's Parent(s)	Father's Parent(s)	Details
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Birth Defects							
Blood Clots							
Bowel Problems							
Cancer – Type							
COPD							
Depression							
Diabetes							
Eye Disease							
Epilepsy / Seizures							
Heart Attack							
Heart Disease							
Heart Murmur							
Heartburn / Reflux							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Lung Disease							
Mental Illness Type:							
Migraines							
Stomach Ulcer							
Stroke							
Suicide / Suicide Attempt							
Thyroid Disease							
Tuberculosis							
Other:							

Patient: **DOB**: **Age**: **Gender**:

Please check any significant medical history in yourself or family members.

Past Surgical History:

Surgery	Reason	Year	Hospital