Thunderbird Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name _____ Birthdate_____ Age _____ Date_____

Allergies to medications/food/environment	Reaction

Current Medications (Prescription, over the counter, herbal)	Prescribing Doctor	Dose	Instructions	Reason Used

What do you do so you don't become pregnant?

____ Diaphragm ____ Condoms ____ Sponge ____ Rhythm ____ IUD
____ Withdrawal ____ Depo Provera ____ Vasectomy ____ Norplant ____ Pills
____ Essure ____ Tugal Ligation ____ Implanon ____ Ortho Evra ____ Nuva Ring
____ Other _____

First day of last period_____
What age were you when you started your first period? _____
Are your periods regular? _____
Is there bleeding between periods? _____
How often do your cycles occur? _____
For how many days do you bleed? _____
Flow is: _____ scant _____ mild _____ mod _____ severe _____ incapacitating
Other symptoms with periods? _____
_____
Date of last pap smear _____
Have you had an abnormal pap smear? No _____ Yes_____
Has this been treated? No _____ Yes_____
How? _____
Do you examine your breasts regularly? No _____ Yes_____
When was your last Mammogram (if any)? _____ Result _____
Do you have concerns about your breasts? _____
When was your last Bone Density (if any)? _____ Result _____

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Name _____ Birthdate_____ Age _____ Date_____

Past Medical / Surgical History (Including Injuries)

Condition/Disease	Date	Treatment

Have you had:
Pain with intercourse? No ___ Yes___
Bleeding with intercourse? No ___ Yes___
Concerns about vaginal discharge? No ___ Yes___ Explain _____
Leaking of urine? No ___ Yes___ Explain _____
Pelvic infections? No ___ Yes___ Explain _____
Sexually transmitted diseases? No ___ Yes___ Explain _____

Total number of pregnancies

Full Term	Premature	Cesarean Section	Vaginal Delivery	Ectopic	Miscarriage	Abortion	Stillborn	Live at Birth	Live at Present

Pregnancy Details

Preg #	Sex	Month/ Year	Number of weeks	Weight	Hrs of Labor	Delivery Type	Obstetrical/Neonatal Problems	Delivery Doctor

Revised 2/20/2011

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Name _____ Birthdate_____ Age _____ Date_____

Family History

Please complete if any of your close relatives have had any of the following:

Disease	Circle Yes/No	Family Member	Family Members 1st Name	Age of Onset	Age of Death	Cause of Death (Circle)
Cancer of Breast	Yes No					Yes No
Cancer of Ovary	Yes No					Yes No
Cancer of Uterus	Yes No					Yes No
Cancer of Cervix	Yes No					Yes No
Cancer of Colon	Yes No					Yes No
Diabetes	Yes No					Yes No
Tuberculosis (TB)	Yes No					Yes No
Heart Disease	Yes No					Yes No
High Blood Pressure	Yes No					Yes No
Other:						Yes No
						Yes No
						Yes No
						Yes No
						Yes No

Social History

Primary Language Spoken_____ Race_____
Do you smoke? No_____ Yes_____ If yes, type of tobacco?_____ Number of years_____ Pks/day_____
Do you drink alcohol? No_____ Yes_____ If yes, type of alcohol_____
How often?_____ Amount_____ Last drink_____
Do you consume caffeine? No_____ Yes_____ If yes, what kind?_____ Amount_____
Do you use recreational drugs? No_____ Yes_____ If yes, what kind?_____
Do you have a regular exercise program? No_____ Yes_____ Hours/week_____
How many sexual partners do you have? None_____ One_____ 2-5_____ 5+_____
Have you been exposed to sexual or physical violence or abuse? No_____ Yes_____
Are there animals in the home? No_____ Yes_____ If yes, what kind?_____
Is the patient the individual who cleans up after the animals? No_____ Yes_____
If medically necessary, would you agree to a transfusion? No_____ Yes_____

Revised 2/20/2011

ACCT # **J G D H A** **HIPAA:**

Thunderbird Obstetrics & Gynecology, Ltd.

5757 West Thunderbird Road, Suite W202
Glendale, AZ 85306

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____

ADDRESS: _____ MARITAL STATUS: M S D W

CITY/ZIP CODE: _____ SOCIAL SECURITY #: _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ **REFERRED BY:** _____

SPOUSE (OR PARENT IF MINOR)

NAME: _____

DOB: _____ SSN#: _____

EMPLOYER: _____

OCCUPATION: _____

WORK PHONE: _____

EMERGENCY CONTACT / Not living with you

NAME: _____

RELATIONSHIP: _____

EMERGENCY #: _____

PRIMARY CARE PHYSICIAN: _____

PCP PHONE: _____

NAME OF AUTHORIZED PARTY / to release medical information _____

PRIMARY INSURANCE (New/change ins? Y N)

NAME: _____

ADDRESS: _____

_____

ID #: _____

GROUP #: _____

INS'D NAME & DOB: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE (New ins/change? Y N)

NAME: _____

ADDRESS: _____

_____

ID #: _____

GROUP #: _____

INS'D NAME & DOB: _____

RELATIONSHIP TO PATIENT: _____

CONSENT FOR TREATMENT / INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize my physician to release any and all information acquired in the course of my examination or treatment to my insurance carrier.

I hereby assign/authorize payment directly to the physician for the medical and/or surgical benefits otherwise payable to me for services provided. I understand that I am financially responsible for the charges not covered/allowed by my insurance. A photocopy of this authorization shall be accepted as the original.

SIGNATURE: _____ **DATE:** _____