WELCOME TO OUR OFFICE

Please Complete this form and return it to the receptionist. PLEASE PRINT.

PATIENT NAME_____ DATE OF BIRTH _____

MAILING ADDRESS _____

CITY_____ STATE ____ ZIP _____ PHONE _____

SOCIAL SECURITY # _____ MARITAL STATUS _____

PATIENT'S EMPLOYER _____WORK PHONE _____

OCCUPATION _____ CELL PHONE_____

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____ WORK PHONE _____

**** IF MARRIED, PLEASE INDICATE SPOUSE'S NAME AND DAYTIME PHONE*****

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE ___ ZIP _____

PHONE NUMBER _____ WORK PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____

POLICY NO._____ GROUP NO. _____ CONTRACT_____

POLICY HOLDER _____ POLICY HOLDER DOB _____

POLICY HOLDER'S EMPLOYER _____

SECONDARY INSURANCE CO. _____

POLICY NO. _____ GROUP NO. _____ CONTRACT _____

POLICY HOLDER _____ POLICY HOLDER DOB _____

POLICY HOLDER'S EMPLOYER _____

_____ _____

DATE SIGNATURE

RELEASE OF INFORMATION

I HERBY AUTHORIZE AND ALLOW BROOME OBSTETRICS AND GYNECOLOGY, PC HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, HOSPITALS, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE, ALL INFORMATION NEEDED FOR MEDICAL TREATMENT, HEALTHCARE OPERATIONS AND TO SUBSTANTIATE PAYMENT FOR SUCH MEDICAL CARE TO PERMIT REPRESENTATIVE THEREOF TO EXAMINNE AND MAKE COPIES OF ALL RECORDS, INCLUDING HIV, RELATING TO SUCH CARE AND TREATMENT.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I HERBY ASSIGN, TRANSFER AND SET OVER TO BROOME OBSTETRICS AND GYNECOLOGY PC SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN SAID MEDICAL GROUP.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

PRIVACY RELEASE

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF BROOME OBSTETRICS AND GYNECOLOGY, PC.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

MEDICARE RELEASE

I CERTIFY THAT THE INFORMATION GIVEN TO ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR ITS CARRIERS, ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS. I REQUEST PAYMENT TO BE MADE TO BROOME OBSTETRICS AND GYNECOLOGY, PC.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE DATE

PAYMENT AND/OR CO-PAYS ARE DUE AT THE TIME OF SERVICE

Patient Name _____ DOB_____

FAMILY HISTORY

Illness	Relative	Age onset	Illness	Relative	Age onset
Y N Breast Cancer			Y N Ovarian Cancer		
Y N Colon Cancer			Y N Other Cancer		
Y N Heart Disease			Y N Hypertension		
Y N Depression/Anxiety			Y N Stroke		
Y N Thyroid Disease			Y N Osteoporosis		
Y N Bleeding Disorders			Y N Mental Retardation		
Y N Birth Defects			Y N Genetic Disease		
Y N Diabetes			Y N Other		

SOCIAL HISTORY

Tobacco Use Y N How Much_____ Number of Years_____
Alcohol Use Y N How Much_____
Recreational Drug Use Y N How Much_____ Number of Years_____
Calcium Intake Y N Calcium Supplement Y N _____
Caffeine Intake Y N How Much_____
Exercise Y N How often_____ Type_____

MEDICATIONS (INCLUDING OVER THE COUNTER)

Medication	Medication	Medication

See Attached List _____

MENSTRUAL HISTORY

Age at first menstrual period _____
Cycle length_____ Flow length_____
Menstrual flow – Light_____ Moderate_____ Heavy _____

If you have stopped having menstrual periods, at what age did you have your last one _____

Date Updated and Reviewed

_____ _____ _____ _____ _____ _____ _____

BROOME OBSTETRICS AND GYNECOLOGY, P.C.

Patient Name _____ Date _____
Date of Birth _____ Primary Care Physician _____
Referred By _____ Physician Address _____
Specialists _____

ALLERGIES (REACTIONS) _____ (_____) _____ (_____)
_____ (_____) _____ (_____) _____ (_____)

PERSONAL MEDICAL HISTORY:

Y N	Heart Disease	Y N	Hypertension	Y N	High Cholesterol
Y N	Stroke	Y N	Bleeding Disorders	Y N	Mitral Valve Prolapse
Y N	Asthma	Y N	Thyroid Disease	Y N	HIV
Y N	Osteopenia	Y N	Osteoporosis	Y N	Joint Replacement
Y N	Diabetes	Y N	Anxiety	Y N	Depression
Y N	GERD	Y N	Peptic Ulcer Disease	Y N	Migraines
Y N	Cancer	Y N	Seizures	Y N	STD Exposure

Other _____

GENETIC TESTING:

Y N BRCA Who was tested _____ Discussed _____
Results _____

Y N Multi-Gene Who was tested _____ Discussed _____
Results _____

FAMILY PLANNING: _____

OPERATIONS/HOSPITALIZATIONS:

Date	Procedure	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OBSTETRICAL HISTORY:

Date	Type of Delivery (Complications)	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEXA scan Y N Date/Where _____ _____ _____
Colonoscopy Y N Date/Where _____ _____ _____
Gardasil Vaccine Y N Date/Where _____ _____ _____

Date Updated and Reviewed

_____ _____ _____ _____ _____ _____ _____

Name:_____ Date:_____ Medical Doctor: _____

Last menstrual period: _____ Medications: _____

Please check any of the following symptoms that apply to you. Thank You.

CONSTITUTIONAL	**YES**	**NO**
Weight loss	___	___
Weight gain	___	___
Change in height	___	___
Fever	___	___
EYES/EARS/NOSE/THROAT		
Vision changes	___	___
Earaches	___	___
Hearing problems	___	___
Sore throat	___	___
Mouth sores	___	___
CARDIOVASCULAR		
Chest pain	___	___
Swelling of legs	___	___
Rapid/irregular heartbeat	___	___
RESPIRATORY		
Coughing up blood	___	___
Shortness of breath	___	___
Chronic cough	___	___
Wheezing	___	___
GASTROINTESTINAL		
Frequent diarrhea	___	___
Bloody stool	___	___
Nausea/vomiting	___	___
Constipation	___	___
Change in bowel habits	___	___
Abdominal bloating	___	___
Frequent indigestion	___	___
Hemorrhoidal pain	___	___
URINARY		
Blood in urine	___	___
Pain with urination	___	___
Strong urgency to urinate	___	___
Frequent urination	___	___
Incomplete emptying	___	___
Involuntary urine loss	___	___
Urine loss w/cough/lift	___	___
GYNECOLOGICAL		
Abnormal bleeding	___	___
Painful periods	___	___
Painful intercourse	___	___
Abnormal vaginal discharge	___	___
Itching	___	___
Possible contact with sexually transmitted disease	___	___
Bleeding with intercourse	___	___

MUSCULOSKELETAL	**YES**	**NO**
Muscle weakness	___	___
Muscle/joint pain	___	___
SKIN		
Bruises	___	___
Rash	___	___
Changes in moles	___	___
BREASTS		
Pain in breasts	___	___
Nipple discharge	___	___
Lumps	___	___
NEUROLOGIC		
Seizures	___	___
Dizziness	___	___
Numbness	___	___
Frequent/severe headaches	___	___
PSYCHIATRIC		
Feeling down/sad	___	___
Feeling anxious	___	___
ENDOCRINE		
Heat/cold intolerance	___	___
Abnormal thirst	___	___
Hot flashes	___	___
Chronic fatigue	___	___
HEMATOLOGIC/LYMPHATIC		
Cuts that do not stop bleeding	___	___
Enlarged lymph nodes/glands	___	___
ALLERGIC/IMMUNOLOGIC		
Medication allergies?	___	___
List:_____		
Other allergies?	___	___
List:_____		
Do you drink alcohol?	___	___
How much?_____		
Do you smoke?	___	___
How much?_____		
Do you exercise?	___	___
Would you like information on domestic violence?	___	___

FEMALE PATIENT HISTORY

IDENTIFYING INFORMATION

Name_____ Date_____
Partner's Name_____
Address_____
Telephone (Day)_____ (cell)_____(evening)_____
e-mail address_____ Duration of Infertility_____
Date of Birth_____ Partner's Date of Birth_____ Duration of Relationship_____
Insurance Company_____ ID#_____
Nature of present employment (title, brief description)_____
_____

MEDICAL HISTORY

Weight _____ Height_____ Blood Type (if known)_____
Have you lost greater than 20 pounds of weight in the last year?..... Y N
Do you have a particular food diet or have any special dietary habits?..... Y N
If yes, specify_____
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began.
Exercise_____Hrs/week_____ Exercise_____ Hrs/week_____
Have you ever had pelvic surgery?..... Y N
If yes, specify date and type:_____
Do you have or have you ever had (check **all** that apply)

___Anemia
___ Appendicitis
___ Arthritis
___ Blood Transfusions
___ Breast Milky Discharge
___ Breast Soreness
___ Breast Tenderness
___ Cancer Specify:_____
_____
___ Chlamydia
___ Chronic Bronchitis
___ Chronic Headaches
___ Colitis
___ Color Blind
___ Diabetes
___ Dizziness
___ Endometriosis
___ Epilepsy
___ Gallbladder Problems
___ Gonorrhea
___ Heart Disease
___ Hepatitis
___ Herpes
___ Hirsutism (excess hair growth)
___ High Blood Pressure
___ Immunization:German Measles
___ Kidney Problems
___ Liver Problems
___ Loss of Balance
___ Measles: German
___ Measles: Regular
___ Neurological Problems
___ Nongonococcal Urethritis
___ Ovarian Cysts
___ Parasitic Infection
___ Pelvic Infection
___ Pneumonia
___ Poor Sense of Smell
___ Rheumatic Fever
___ Scarlet Fever
___ Seizures
___ Syphilis
___ Thyroid Problems
___ Tuberculosis
___ Ulcers
___ Vaginitis (trichomoniasis, yeast) # of episodes_____
___ Visual Disturbances
___ Any Allergies: List
_____
_____

Have you ever been treated for cancer?..... Y N
If yes, explain therapy:_____
Have you ever received X-rays to the pelvic area for therapy or diagnosis..... Y N
If yes, specify:_____
Within the last year, have you taken any prescription medication..... Y N
If yes, list all prescriptions and problems for which you were taking them:_____
_____
_____
Are you taking any over-the-counter medications on a regular basis..... Y N
If yes, list all medication and diagnosis_____
_____

Do you use or have you ever used (check all the apply)

___ Alcohol – How many glasses per week do you usually drink? Wine_____Beer_____Cocktails_____

___ Cigarettes – Number of packs per day_____

___ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) if you would feel more comfortable not writing down, please discuss this directly with your physician. Specify:_____

_____

MENSTRUAL AND PREGNANCY HISTORY

Age at first period?_____ When was your last period_____

Are your periods regular?..... Y N

If yes, what is the usual number of days between periods?_____

If no, how many times per year do you menstruate_____

What is the usual duration of your period?_____ Use: ____ Tampons ___ Pads

Are cramps present before, during or after your period?..... Y N

Are cramps: ___ Mild ___ Moderate ___ Severe

Do you have to take pain medication for cramps..... Y N

If yes, specify medication:_____

Do you bleed or spot between periods?..... Y N

How many pregnancies (including abortions) have you had?_____

PREGNANCY

When (year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility therapy required to conceive	How long to conceive	Baby born alive?	Is current partner the father?

Were there any complications during or after your pregnancies?..... Y N

If yes, explain_____

Did your mother have any difficulty with conception or pregnancy?..... Y N

If yes, explain_____

How long have you now been trying to get pregnant?_____

Did you mother take diethylstilbestrol (DES) when she was pregnant with you?..... Y N

CONTRACEPTIVE/SEXUAL HISTORY

What form of contraception do you use now or have you used in the past? Check all that apply:

___ Pills Name_____ ,___IUD Name_____ ,___ Diaphragm ,___ Withdrawal

___ Foams/Jellies, ___ Condom, ___Rhythm, ___None, ___Other_____

For each contraceptive method used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation

If you've ever been on oral contraceptive (pills) were your periods regular after stopping the pill? Y N

How many times per week do you and your partner have sexual intercourse?_____

How many times do you have intercourse around ovulation?_____

Is intercourse painful or difficult for you?..... Y N

Do you use lubricants for intercourse?..... Y N

If yes, which ones?_____

Do you douche before or after intercourse?..... Y N

FAMILY HISTORY

Is there a family history of infertility?..... Y N

If yes, who (list all members and relationship to you)_____

_____

Is there a family history of hormonal disorders in your family..... Y N

If yes, who and what type_____

_____

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?..... Y N

If yes, who was your physician?_____

What cause of infertility was diagnosed?_____

What drugs have you taken for infertility? Check all that apply;

___ Clomiphene citrate (Serophene, Clomid)
___ hMG (Pergonal)
___ Estrogens
___ Progesterone
___ Antibotics
___ GnRH or LHRH (Factrel)
___ Gonal f
___ hCG (Profasi, A.P.L.)
___ Bromocriptine (Parlodel)
___ Danazol (Danocrine)
___ Urofollitropin or FSH (Metrodin)
___ Other – Specify_____
___ None

Which of the following tests have you had performed? Check all that apply and results if known:

___ BBT When _____ Results_____
___ Postcoital Test When _____ Results_____
___ Hormonal Assays (FSH, LH, Prolactin, estrogen DHEA-S, testosterone, progesterone) When_____ Results_____
___ Endometrial Biopsy When_____ Results_____
___ Hysterosalpingogram When_____ Results_____
___ Ultrasound When_____ Results_____
___ Antibodies When _____ Results_____
___ Laparoscopy, Hysteroscopy When _____ Results_____
___ Mycoplasma/Chlamydia Cultures When _____ Results_____
___ Thyroid Tests When _____ Results_____
___ Other – Specify_____ When _____ Results_____

Have you ever had surgery for tubal reversal?..... Y N

If yes, specify dates_____

Have you ever had surgery for lysis of adhesions?..... Y N

Have you ever had cervical conization or cautery?..... Y N

Have you ever had any other surgery (D&C, Ovarian, appendectomy, thyroid)?..... Y N

If yes, please specify:_____

Have you ever undergone artificial insemination or in vitro fertilization?..... Y N

If yes, using partner or donor sperm?_____

Is you partner seeing a doctor for evaluation if infertility?..... Y N

If yes, specify physician name and location_____

Does the doctor feel that your partner has an infertility problem..... Y N

If yes, what is the diagnosis and how is he being treated?_____

_____

Has your partner ever fathered a child with another woman?..... Y N

If yes, when:_____

MALE PATIENT HISTORY

IDENTIFYING INFORMATION

Name_____ Date_____
Partner's Name_____
Address_____
Telephone (Day)_____ (cell)_____ (evening)_____
e-mail address_____ Duration of Infertility_____
Date of Birth_____ Partner's Date of Birth_____ Duration of Relationship_____
Insurance Company_____ ID#_____

TRAVEL/WORK AND GENERAL BACKGROUND
All present employment (titles, location, brief description and number of years employed)

_____
_____
_____

Are you or have you ever been exposed to any of the following during employment or military service:
___ Heat ___ Toxic Fumes ___ Other Specify:
___ Chemicals ___ Nuclear Radiation _____

MEDICAL HISTORY
Weight _____ Height _____ Blood Type (if known)_____
Have you lost greater than 20 pounds in the last year?..... Y N
Do you follow a particular food diet or have any special dietary habits?..... Y N
If yes, specify:_____
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:
Exercise_____Hrs/Week_____ Exercies_____ Hrs/Week_____
Do you frequently take saunas or steam baths?..... Y N
Have you ever had surgery in the pelvic area?..... Y N
If yes, specify date and type of surgery:_____
Have you ever received X-rays in the pelvic area for therapy or diagnosis?..... Y N
If yes, explain_____
Do you have or have you ever had (check **all** that apply)

___ Anemia
___ Appendicitis
___ Arthritis
___ Blood Transfusion
___ Breast Milky Discharge
___ Breast Soreness
___ Breast Soreness
___ Breast Tenderness
___ Cancer? Specify_____
_____
___ Chlamydia
___ Chronic Bronchitis
___ Chronic Headaches
___ Colitis
___ Cystic Fibrosis
___ Diabetes
___ Dizziness
___ Epilepsy
___ Gallbladder Problems
___ Gonorrhea
___ Heart Disease
___ Hepatitis
___ Herpes
___ High Blood Pressure
___ Kidney Infection
___ Liver Problems
___ Loss of Balance
___ Measles: German
___ Measles: Regular
___ Mumps
___ Mumps with Testes involved
___ Neurological Problems
___ Nongonococcal Urethritis
___ Parasitic Infection
___ Pneumonia
___ Prostatitis
___ Rheumatic Fever
___ Scarlet Fever
___ Seizures
___ Syphilis
___ Testes Infection
___ Testes Injury
___ Testes Tumor
___ Thyroid Problems
___ Tuberculosis
___ Ulcers
___ Visual Disturbances
___ Any Allergies? List _____
_____

Have you ever been treated for cancer?..... Y N
If yes, explain therapy_____
Within the last year, have you taken any prescription medications..... Y N

If yes, list all prescriptions and problems for which you were taking them_____

_____

Are you taking any over-the-counter medications on a regular basis?..... Y N

If yes, list all medications and diagnoses_____

_____

Have you had a high fever (over 102 F) during the past 3-4 months?..... Y N

Do you use or have you ever used (check all that apply)

___ Alcohol – How many glasses per week do you usually drink? Wine____, Beer____, Cocktails____

___ Cigarettes – Number of packs per day_____

___ Illicit or Recreational Drugs (Marijuana, Cocaine, etc) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify_____

_____

SEXUAL HISTORY

Are you circumcised?..... Y N

When you were a child, were both testes descended into the scrotum?..... Y N

At what age did you begin shaving regularly or start to grown a beard?_____

How many times have you been married?_____

Have you ever produced a child with another partner?..... Y N

If yes, how long did it take to produce a child_____ When was this (date)_____

Have you ever tried to produce a child with another partner..... Y N

Do you have trouble getting an erection?..... Y N

Maintaining an erection?..... Y N

Do you have trouble with ejaculations?..... Y N

If yes, ___Premature ejaculations, ___ Retrograde ejaculations?

Do you feel that some of your ejaculate is deposited in the vagina?..... Y N

Do you ever have orgasms without ejaculation during masturbation?..... Y N

Do you have any discharge from the penis?..... Y N

How many times per week do you and your partner now have intercourse?_____

How many times do you have intercourse around ovulation?_____

Have you noticed a change in your sexual drive recently?..... Y N

FAMILY HISTORY

Is there a family history of infertility?..... Y N

If yes, who (list all members and relationship to you)_____

_____

Is there a history of hormonal disorders in your family?..... Y N

If yes, list who (relationship to you) and what type_____

_____

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?..... Y N

If yes, who was your physician?_____

What cause of infertility was diagnosed?_____

What drugs have you taken for infertility? Check all that apply

___ clomiphene citrate (Serophene, Clomid)
___ hMG (Pergonal)
___ tamoxifen
___ Testolactone
___ bromocriptine (Parlodel)
___ testosterone or Male Hormone
___ hCH (Profasi, A.P.L.)
___ fluoxymesterone (Halotestin)
___ GnRH or LHRH (Factrel)
___ urofollitropin or FSH (Metrodin)
___ Other _____
___ None

Have you ever had varicocele repair?..... Y N

Have you ever had vasectomy reversal or repair?..... Y N

If yes, when?_____

Have you and your partner ever tried artificial insemination?..... Y N
If yes, using ___your sperm, ___donor sperm?
Have you and your partner ever tried in vitro fertilization?..... Y N
If yes, when and explain _____

_____

Which of the following tests have you had performed? Check all that apply and the results if know.

___ Semen Analysis When_____ Results_____
___ Chlamydia Test When_____ Results_____
___ Mycoplasma Test When_____ Results_____
___ Antibody Test When_____ Results_____
___ Hamster Egg Test When_____ Results_____
___ Chromosome Test When_____ Results_____
___ Testicular Biopsy When_____ Results_____
___ X-Ray or Ultrasound of testes When_____ Results_____
___ Hormonal Tests (FSH, LH, Prolactin. Testosterone) When_____ Results_____
___ Thyroid Tests When_____ Results_____
___ Other, _____ When_____ Results_____

Is your partner currently seeing a doctor for evaluation of infertility?..... Y N
If yes, specify physician name and location_____

_____

Does the doctor feel that your partner has an infertility problem?..... Y N
If yes, what is the diagnosis and how is she being treated?_____

_____

Has she ever had children with another man?..... Y N
If yes, when_____