County Obstetrics & Gynecology

Patient Demographics

First and Last Name					Birthdate			
Street Address					Apt#			
City		State			Zip Code			
Social Security								
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed				

Contact Information:			
Mobile Phone #			
Home Phone #			
Work #			
Email:			
Employment:	☐ Employed	☐ Unemployed	☐ Student
Employer:			
Main Phone #			
Emergency Contact:		Relationship	
Mobile #			
Pharmacy Name			
Pharmacy Pone #			
Mail-order Pharmacy			
Mail-order Pharmacy #			

Insurance Information					
Primary Insurance Name					
Policyholder's Name		D.O.B.			
Identification Number (I.D.)					
Group I.D. Number					
Effective Date					
Secondary Insurance Name					
Policyholder's Name		D.O.B.			
Identification Number					
Group I.D. Number					
Effective Date					

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Health Information

	Birth Date	- -	
Drug Allergies	☐ No	☐ Yes	
List medication allergies:			
Latex Allergies	☐ No	☐ Yes	
Medication			

1		4	
2		5	
3		6	

Social History			
Tobacco Use	☐ No	☐ Yes	☐ Former
		Years of Use:	Year Quit:
Vape Use	☐ No	☐ Yes	☐ Former
		Years of Use:	Year Quit:
Recreational Drug Use	☐ No	☐ Yes	☐ Former
Alcohol Use	☐ No	☐ Yes	☐ Daily

Medical Conditions	Additional Details		Additional Details
Choose an item.		Choose an item.	
Choose an item.		Choose an item.	
Choose an item.		Choose an item.	

Surgical History					
List Surgeries					
Gynecological History					
Age of first Period		Age of Menopause			
Have you ever had an abnormal pap test?	☐ Yes ☐ NO	How was it treated?		HPV Vaccine	☐ Yes ☐ NO
Obstetrical History					
Your age at first delivery		Total number of pregnancies			

Year	Type of delivery	Weight	Gender	Number of weeks	Complications
	Delivery type		Gender		
	Delivery type		Gender		
	Delivery type		Gender		
	Delivery type		Gender		

Family History		
Medical Illness:		
Common Hereditary Cancer		Age of Onset
Choose an item.	Choose an item.	
Choose an item.	Choose an item.	
Choose an item.	Choose an item.	
Choose an item.	Choose an item.	
Choose an item.	Choose an item.	