Suzanne Trupin, OB/GYN

Women's Health Practice
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womenshealthpractice.com

PATIENT INFORMATION

Gender: (Circle one) Female/Male Date: _____

Patient Name: _____
Last First Middle

Previous and/or Maiden Name(s):_____

Date of Birth: _____ SS #: _____

Street Address: _____

City/State/Zip: _____

Phone Numbers: Cell: _____ Home: _____ Work: _____

Email address: _____

Marital Status (Circle one): Married _____ years Widowed Divorced Single Separated Domestic Partnership

Race: (Circle one) American Indian/Alaska Native Asian Black or African American Caucasian/White
Hispanic Middle Eastern Native Hawaiian or other Pacific Islander Other

Ethnicity: (Circle one) Hispanic or Latino Non Hispanic or Latino Refuse to Report

Language (check boxes) ☐ Arabic ☐ Cantonese ☐ English ☐ Hebrew ☐ Japanese ☐ Korean ☐ Mandarin ☐Russian
☐Spanish ☐Other: _____

Patient's Employer: _____

Address:_____

Spouse's Name (if applicable): _____ SS #: _____

Spouse's Employer: _____
Address: _____

Primary Insurance Company: _____
Address:_____
Policy Holder: _____
ID Number: _____ Relationship to Patient: _____
Policy Holder Birthdate & Address (if other than patient):_____
_____

Secondary Insurance Company: _____
Address:_____
Policy Holder: _____
ID Number: _____ Relationship to Patient: _____
Policy Holder Birthdate & Address (if other than patient):_____
_____

Policy Holder's Employer: _____
Address: _____

How did you hear about our office? □ Yellow Pages □ Internet □ Friend/Coworker □ Ads
□ Physician (name/address): _____
_____
□ Other: _____

Emergency Contact Person: _____

Address: _____

Phone Number(s): _____

Circle the Main Reason for which You Are Seeing the Doctor:

Abnormal pap smear	Contraception	Juvederm (Fillers)	Sexuality Issues
Annual Physical	Cosmetic	Labiaplasty	STD Exposure
Anti-Aging	Depression	Menopause	Second Opinion
Botox	Infertility Evaluation	Pain/Discharge	Urinary/Bladder Problems
Cool Sculpting	Irregular Bleeding	Pregnancy	Other: _____

Circle Any of the Following That Have Occurred in Your Family:

Arthritis	Cardiac Disease	High Blood Pressure	Other: _____
Birth Defects	Diabetes	Mental Illness	_____
Cancer	Genetic Problems	Strokes	_____

Menstrual Cycle:

Started at age: _____ Number of days from the start of one cycle to the start of the next: _____

First day of last normal cycle: _____ Cycle lasts _____ days.

Do you bleed between cycles? ☐ Yes ☐ No

Date of last ***Pap smear:*** _____

Number of previous pregnancies: _____

Full-term babies _____ Premature: _____ Miscarriages: _____

Terminations: _____ Stillborn: _____ Living Children: _____

Method of birth control used: _____

Do you have a Primary Care Physician? _____ If yes, name of Primary Care Physician _____

List previous surgeries including dates (be specific): _____

_____

List any recent hospitalizations: _____

_____

List any prescription medications you are taking: _____

_____

List any over-the-counter medications you are taking: _____

_____

Circle if you use or have ever used: Alcohol Cigarettes Recreational Drugs

Circle all conditions which you now have or have ever had:

Anemia	Colitis	High blood pressure	Pelvic pain
Appendicitis	Diabetes	Hirsutism (excess hair growth)	Pulmonary disease
Arthritis	Dizziness	Kidney infection	STD
Blood transfusion	Endometriosis	Liver problems	Thyroid problems
Breast discharge	Fibroids	Neurologic seizure/disorder	Tuberculosis
Breast pain	Gallbladder problems	Other: _____	Ulcers
Breast tenderness	Heart disease	_____	Urinary problems
Cholesterol problems	Hepatitis	Ovarian cysts	Vaginitis
Chronic headaches	Herpes	Pelvic infection	Visual disturbances

Immunizations:

DPT MMR Hepatitis B Influenza Mumps Polio Rubella

Gardasil 1) _____ 2) _____ 3) _____ Shingles TB Chicken Pox

Cancer (specify): _____

Allergies: _____

The Centers for Disease Control and Prevention (CDC) recommends HIV testing be included as part of routine annual care for all patients' ages 18 to 45. This means that HIV testing would be included with my medical examination. Check one of the following:

☐ ***I consent to HIV testing per CDC recommendation.*** ☐ ***I do NOT consent to HIV testing per CDC recommendation.***

Signature of Patient or Patient/Guardian: _____

Patient Name (print): _____