

ATRIUM

OB/GYN, INC.

4151 HOLIDAY STREET, N.W. – CANTON, OHIO 44718 – TELEPHONE (330) 492-8001
FAX (330) 492-2080 – WWW.ATRIUMOBGYN.COM

Dear Patient:

On behalf of our physicians, nurse practitioners and staff, welcome to Atrium OB/GYN, Inc. Please complete the attached forms and mail or drop off to our office prior to your appointment date so that we can prepare for your visit in advance. We would also appreciate having a copy of your previous medical records.

For your first visit please arrive at our office at least 20 minutes prior to your appointment time. Upon registration, you will be asked to read and sign our HIPAA patient confidentiality policy, which describes how your medical records are protected in our practice.

If you have insurance coverage you will need to present your insurance card(s) at the time of your appointment. Co-pays and deductibles are also due at this time. If you do not present your insurance card(s), you will be responsible for full payment at the time of your visit. We would then provide you with a receipt for you to turn into your insurance carrier. We require a copy of your current card at every visit.

If you have paperwork that needs to be filled out in order to obtain mail order prescriptions, please bring that with you to your visit.

You will be considered an active patient in our practice once you have been seen by one of our physicians and/or the nurse practitioners for an exam.

Again, welcome to our practice and we appreciate the trust you have placed in us for your health care. We are looking forward to meeting you.

Thank You,

Physicians and Staff at Atrium OB/GYN, Inc.

***Please complete and return this medical history form promptly by mail. Thank you.**

NAME _____ AGE _____

APPOINTMENT DATE _____ TIME _____

WITH _____

MEDICAL HISTORY

MEDICATIONS

<u>Name of medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>To Treat What Condition?</u>
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ALLERGIES

<u>Drug</u>	<u>What Happens When You Take This Drug?</u>
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OPERATIONS

<u>Type</u>	<u>When</u>	<u>Where</u>	<u>Diagnosis or Symptom</u>
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HOSPITALIZATIONS (other than for surgery listed above or childbirth)

<u>Diagnosis</u>	<u>When</u>	<u>Where</u>
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CURRENT MEDICAL CONDITIONS in yourself (include thyroid, heart or lung diseases, high blood pressure, diabetes, epilepsy, etc.) _____

YOUR MEDICAL DOCTOR(S): _____

Patient Name _____ DOB: ____/____/____

SOCIAL HISTORY

Occupation: _____ Marital Status: (circle one) M S W D SEP

Smoking: _____ (how many) packs per day for _____ (how many) years

Alcohol: _____ (number) drinks per day / week / month (circle one)

Recreational Drug Use:

Special Diet:

Exercise Routine:

FAMILY HISTORY

List medical illness in your family members (include diabetes, high blood pressure, heart disease, endometriosis, birth defects, or other diseases in family).

Mother:

Father:

Brothers:

Sisters:

Is there any personal or family history of cancer? If so, who (what relationship to you), what type of cancer, and at what age was it found?

Relationship

Type of Cancer

Age

MENSTRUAL HISTORY

Age at first period _____ Age at menopause (if applicable) _____

If menstruating: Period interval (1st day to 1st day) averages _____ days.
Duration is approximately _____ days.

If irregular periods, closest interval is _____ days;
farthest interval is _____ days.

The amount of bleeding is (circle) light / moderate / heavy.
If heavy, pad or tampon change is every _____ hours for _____ days.

Patient Name _____ DOB: ____/____/____

Do you have pain or cramps with your period? (circle one) YES NO
If so, if treatment is needed, what do you take for it? _____
Does it work? (circle one) YES NO

Do you bleed or spot between periods? (circle one) YES NO

If yes, describe _____

Do you bleed or spot after intercourse? (circle one) YES NO

If menopausal, have you had any bleeding after menopause? YES NO

If yes, describe _____

CONTRACEPTIVE HISTORY

Present method of contraception (if applicable) _____

Previous methods used:

<u>Method</u>	<u>Duration</u>	<u>Side Effects</u>
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GYNECOLOGIC HISTORY (circle one)

Do you have pain in your pelvis or female organs? YES NO

If yes, explain: _____

Do you have pain with intercourse? YES NO

If yes, explain: _____

Sexual history: _____ Satisfactory _____ Wish to discuss

Do you or other female family members have a history of endometriosis? YES NO

If yes, explain: _____

Do you have a history of infertility? YES NO

If yes, explain: _____

Results of testing or what treatment given: _____

Patient Name _____ DOB: ____/____/____

Do you have a history of any of the following infections?

_____infection in tubes or pelvis requiring antibiotics		
_____yeast	_____trichomonas	_____G. vaginalis
_____syphilis	_____chlamydia	_____group B strep
_____herpes	_____gonorrhea	_____genital warts

Do you have a problem with male pattern hair that requires you to shave, etc.? YES NO

If yes, explain: _____

Have you ever used hormones in the past including estrogen, progesterone, thyroid, steroids, or birth control pills? Duration: _____ YES NO

Explain: _____

Side Effects: _____

Do you have:

- a feeling of pressure or a "falling out" sensation in your vagina?	YES	NO
- difficulty holding your urine?	YES	NO
- difficulty starting to void?	YES	NO
- difficulty having a bowel movement?	YES	NO

Explain: _____

Your last PAP and gynecologic exam: Date _____ Normal _____ Abnormal _____

If abnormal, explain: _____

Have you ever had an abnormal PAP smear? YES NO

If yes, explain: _____

BREAST DISEASE:

Have you ever had any breast lumps? YES NO

Have you ever had any breast discharge? YES NO

If yes, explain diagnosis and treatment _____

Last mammogram: Where: _____ When: _____

Result: _____

Patient Name _____ DOB: ____/____/____

OBSTETRICAL HISTORY

Total number of pregnancies _____

Premature babies _____

Miscarriages _____

Elective Terminations _____

Living children _____

Ectopic pregnancies _____

Stillbirths _____

Twins _____

Describe all pregnancies

	#1	#2	#3	#4	#5
Date					
Type of delivery (vaginal, forceps, c-section, vacuum)					
Anesthesia (natural, spinal, epidural, general)					
Weeks +/- due date					
Length of labor					
Birth weight					
Sex					
Complications					
Status of child					

Patient Name _____

DOB: ____/____/____

DO YOU HAVE OR HAVE YOU HAD A PROBLEM WITH ANY OF THE FOLLOWING CONDITIONS?

Comment on positive responses **only**. You may use the back of this page if additional room is needed.

Skin/hair problems _____

Headaches/migraines _____

Eye/ear/nose/throat problems _____

Respiratory problems _____

Jaundice/hepatitis/liver disease _____

TB _____

Gall bladder disease _____

Asthma _____

Bowel problems _____

Bronchitis _____

Blood in stools _____

Cough _____

Diarrhea _____

Pneumonia _____

Constipation _____

Stomach problems _____

Colitis _____

Esophagus _____

Hemorrhoids _____

Ulcer Disorder _____

Kidney problems/infeciton/stones _____

Nausea _____

Bladder problems or Incontinence _____

Vomiting _____

Frequency _____

Hiatal hernia _____

Urgency _____

Anemia/blood disorders/sickle cell _____

Burning _____

Blood transfusions _____

Blood in urine _____

Blood clots/embollism/stroke _____

Unable to empty _____

Heart disease _____

Leaking w/cough or sneeze _____

Rheumatic fever _____

Varicose veins _____

Chest pain _____

Epilepsy/neurologic disorder _____

Palpitations _____

Hormone Disorder _____

Elevated cholesterol _____

Psychiatric illness/depression _____

High Blood pressure _____

Fainting/dizziness _____

Major injuries _____

Diabetes _____

Thyroid Condition _____

Hernia _____

Birth defects/inherited diseases _____

Muscle/bone/joint disease (arthritis) _____

Parasitic Infections _____

History of rape/abuse _____

AIDS/ARC _____

Other:

Patient Name _____

DOB: ____/____/____

TODAY'S DATE _____

PATIENT INFORMATION:

Name _____ Maiden Name _____
last first MI

Address _____

Social Security #: _____ Home Phone _____

Birth Date _____ Age _____ Marital Status (circle one) M S W D Sep

Employer _____ Work Phone _____

Husband's Name _____ Social Security # _____
last first MI

Employer/Work Phone _____

IF UNDER 18 AND/OR INSURED BY PARENT OR GUARDIAN:

Parent/Guardian/Spouse Name _____ Birthdate _____
last first MI

Address _____

Home Phone _____ Social Security # _____

Employer _____ Work Phone _____

INSURANCE INFORMATION (Please bring your insurance card/s, and referral if needed, to your appointment). If you do not have insurance please notify the office before your appointment date.

Primary _____ Secondary _____

Insured's Name _____ Insured's Name) _____

ID# _____ ID# _____

Group/No. _____ Group/No. _____

Effective Date _____ Effective Date _____

HOSPITAL LABORATORY INFORMATION:

1ST Day of Last Menstrual Period _____ Mother's First Name _____
(for hospital cross reference)

EMERGENCY INFORMATION (other than a person living with you)

Name _____ Relationship _____

Address _____ Phone _____

REFERRED BY: _____

Patient Name _____ DOB: ____/____/____



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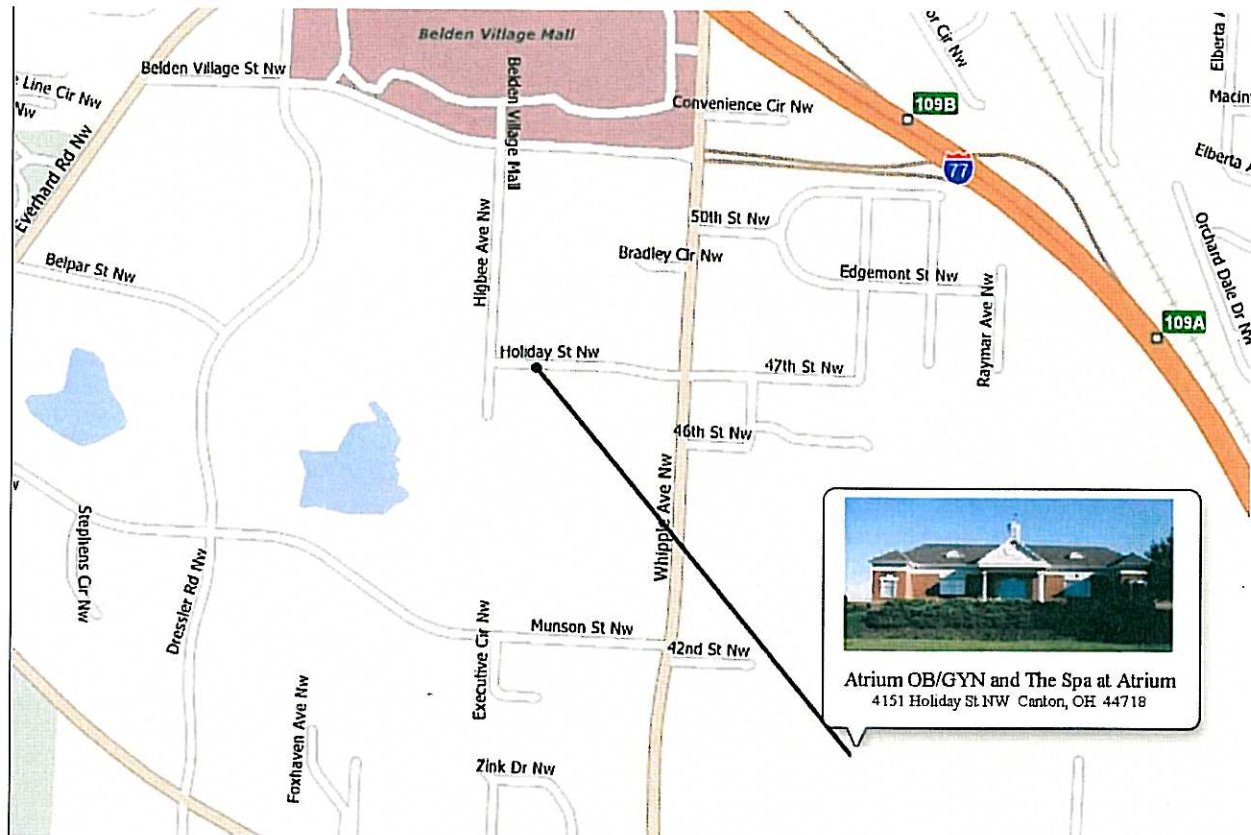
Directions

From Akron

Take I-77 South to Exit 109 (Everhard / Whipple). Turn left onto Everhard and then right at the next light onto Whipple Ave. Continue down Whipple and turn right onto Holiday St. at the second light. Arrive at Atrium OB/GYN 4151 Holiday St. N.W.

From Canton

Take I-77 North to Exit 109A (Belden Village / Whipple). Turn Left onto Whipple Ave. and right at the next light onto Holiday St. Arrive at Atrium OB/GYN 4151 Holiday St. N.W.



Thank you for allowing us to serve you!