LSU Health Shreveport
University Ob/Gyn

Patient Information

PERSONAL INFORMATION

Patient Name:_____
(Last) (First) (Middle Initial)

Maiden Name: _____ Preferred / Nickname: _____

Date of Birth:_____/_____/_____ Age:_____ Social Security #: _____-_____-_____

Marital Status:_____ Spouse Name:_____ Date of Birth:_____/_____/_____

Address: _____
(Street) (Apartment #)

_____
(City) (State) (Zip) County / Parish

Home Phone: _____ Cell Phone: _____

Email Address: _____

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American
☐ Nat Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Declined ☐ Hispanic / Latino ☐ Not Hispanic / Latino

EMPLOYMENT INFORMATION

Patient's Employer:_____

Address: _____
(Street) (City, State, Zip)

Phone: _____ Ext.: _____

Position / Job Title: _____

Status: ☐ Full-time ☐ Part-time

Spouse's Employer: _____

Address: _____
(Street) (City, State, Zip)

Phone: _____ Ext.: _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who may we notify (other than spouse).

Name:_____ Relationship: _____

Home / Work Phone: _____ Cell Phone: _____

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Patient Information (page 2)

Patient Name:_____ Date of Birth:_____/_____/_____

Drug Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Other: _____

MEDICATIONS

Drug Name	Dosage	Prescribing Physician

Reason for visit today: _____

Medical History: _____

_____

Surgical History: _____

_____

PERSONAL MEDICAL HISTORY

Total pregnancies: _____ Living children:_____ Miscarriages:_____ Abortions:_____

Full term:_____ Preterm:_____ Tubal pregnancies:_____

Year of your delivery	Vaginal	C-Section	Year of your Delivery	Vaginal	C-Section
_____	☐	☐	_____	☐	☐
_____	☐	☐	_____	☐	☐
_____	☐	☐	_____	☐	☐

Check if you have ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HIV ☐ Syphillis

Have you ever been tested for HIV? ☐ Yes ☐ No

Date tested:_____ Results: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No Date:_____

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Patient Information (page 3)

Patient Name:_____ Date of Birth:_____/_____/_____

MENSTRUAL HISTORY

Age of onset:_____ Frequency: Every_____ Duration of flow:_____days

Flow: ☐ Light ☐ Medium ☐ Heavy Cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Irregular Bleeding: ☐ Yes ☐ No Treatment required: ☐ Yes ☐ No

Date of last period: _____ Birth control method: _____

History of abnormal pap smears: ☐ Yes ☐ No Treatment required: _____

Age of menopause: _____ Currently on hormones: ☐ Yes ☐ No

Previous hospitalizations: _____

_____

SOCIAL HISTORY

Alcohol use? .....☐ Yes ☐ No Drinks per day:_____ Drinks per week: _____

Illegal drug use? .....☐ Yes ☐ No Type _____

Do you smoke:.....☐ Yes ☐ No Packs per day_____

Do you exercise?....☐ Yes ☐ No How often?_____

FAMILY HISTORY

Please list the family member who has or has had the following:

Breast cancer: _____ Osteoporosis: _____

Colon cancer: _____ Ovarian cancer: _____

Diabetes: _____ Stroke: _____

Heart disease: _____ Thyroid disease: _____

High blood pressure: _____ Gynecologic cancer: _____

Kidney disease: _____ Other: _____

Genetic or inherited disorders: _____

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Patient Information (page 4)

Patient Name:_____ Date of Birth:_____/_____/_____

PHARMACY INFORMATION

Pharmacy name: _____ Location:_____

Phone: _____ Fax:_____

PHONE MESSAGES

Messages can be left on: Home phone:..... ☐ Yes ☐ No

Work phone:..... ☐ Yes ☐ No

Cell phone ..... ☐ Yes ☐ No

INSURANCE INFORMATION

PRIMARY insurance company: _____

Insured's name: _____ Date of birth:_____/_____/_____

Policy / ID Number:_____ Group #: _____

Relationship to patient:_____ Effective date of coverage:_____

Does your insurance policy have Wellness Benefits? ☐ Yes ☐ No

SECONDARY insurance company: _____

Insured's name: _____ Date of birth:_____/_____/_____

Policy / ID Number:_____ Group #: _____

Relationship to patient:_____ Effective date of coverage:_____

Does your insurance policy have Wellness Benefits? ☐ Yes ☐ No

REFERRAL INFORMATION

How did you hear about our office? ☐ Another patient, friend ☐ Another patient, relative

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other: _____

Referred by: _____