Welcome to Ohio Reproductive Medicine

1 Patient Information

Social Security # _____ Date_____

Patient Name_____ _____ _____

Addresss _____

City _____ State _____ Zip _____

Email _____ Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Partnered for _____years ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

Patient Employer/School_____ Employer/School Phone (_____) _____

Employer/School Address_____

Spouse/Partner Name _____ Birthdate _____

Spouse/Partner Social Security # _____

Phone Numbers

Home (_____) _____ Cell (_____) _____ Best Time to be reached and where?_____

In case of emergency please contact: Name _____ Relationship _____

Home (_____) _____ Cell (_____) _____

Whom can we thank for referring you? _____

2 Insurance Information

Who is responsible for this account? Relationship to Patient

Primary Insurance

Insurance Co._____ ID# _____ Group # _____

Insurance Co. Address_____ Insurance Phone # (____) _____

Is patient covered by additional insurance? ❑ Yes ❑ No Subscriber Name _____

Relationship to patient _____ Birthdate _____ SS# _____

Secondary Insurance

Insurance Co._____ ID# _____ Group # _____

Insurance Co. Address_____ Insurance Phone # (____) _____

Insurance Agreement and Release

I certify that I have coverage with (Name of Insurance Company(ies) _____ and assign directly to Ohio Reproductive Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physicians office may use my health care information and may disclose such information tot he above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This Consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient/Parent or Guardian/Personal Representative Date

_____ _____

Printed name of Patient/Parent or Guardian/Personal Representative Relationship to Patient

CONTINUED ON BACK

3

Health History

Date of last Physical Exam_____ Reason for visit? _____

Past Surgery _____Date Surgery _____ Date _____

Past Surgery _____Date Surgery _____ Date _____

Family History

Father ❑ Alive ❑ Deceased Present health or cause of death _____

Mother ❑ Alive ❑ Deceased Present health or cause of death _____

Brothers #Alive _____ Health_____ # Deceased_____ Cause of Death? _____

Sisters #Alive _____ Health_____ # Deceased_____ Cause of Death? _____

Children #Alive _____ Health_____ # Deceased_____ Cause of Death? _____

Check any illnesses which have occurred in any of your BLOOD RELATIVES:

❑ Diabetes ❑ Cancer ❑ Stroke ❑ Heart Disease ❑ High Blood Pressure ❑ Kidney Disease ❑ Bleeding Tendency ❑ Nervous Illness ❑ Tuberculosis

❑ Other _____

Medications / Allergies

Medication_____ Dosage_____ Allergy_____ Reaction _____

Medication_____ Dosage_____ Allergy_____ Reaction _____

Medication_____ Dosage_____ Allergy_____ Reaction _____

Pharmacy Name _____ Phone Number _____

Health Habits

Check which one you use and how much:

❑ Caffeine _____ ❑ Tobacco _____ ❑ Street Drugs_____

❑ Other _____

Check symptoms you have had in the past

General:

❑ Chills ❑ Depression/Nervousness ❑ Dizziness/Fainting ❑ Fever ❑ Forgetfulness ❑ Headache ❑ Loss of Sleep ❑ Loss of Weight ❑ Numbness ❑ Sweats ❑ Joint Pain

GENITO-URINARY:

❑ Blood in Urine ❑ Frequent Urination ❑ Lack of Bladder Control ❑ Painful Urination

GASTROINTESTINAL:

❑ Appetite Poor ❑ Bloating ❑ Bowel Changes ❑ Constipation ❑ Diarrhea ❑ Excessive Thirst ❑ Gas ❑ Indigestion ❑ Nausea ❑ Rectal Bleeding ❑ Hemorrhoids ❑ Stomach Pain ❑ Vomiting ❑ Vomiting Blood

CARDIOVASCULAR:

❑ Chest Pain ❑ High/Low Blood Pressure ❑ Irregular/Rapid Heartbeat ❑ Poor Circulation ❑ Swelling of Ankles ❑ Varicose Veins

EYE, EAR, NOSE, THROAT:

❑ Bleeding Gums ❑ Blurred Vision ❑ Difficulty Swallowing ❑ Double Vision ❑ Earache/Ear Discharge ❑ Hayfever ❑ Hoarseness ❑ Loss of Hearing ❑ Nosebleeds ❑ Persistent Cough ❑ Ringing In Ears ❑ Sinus Problems ❑ Vision-Flashes/Halos

SKIN:

❑ Bruise Easily ❑ Hives ❑ Itching/Rash ❑ Change in Moles ❑ Scars ❑ Sore that won't Heal

GYN HISTORY:

❑ Abnormal Pap Smear ❑ Bleeding Between Periods ❑ Breast Lump ❑ Extreme Menstrual Pain ❑ Hot Flashes ❑ Nipple Discharge ❑ Painful Intercourse ❑ Vaginal Discharge ❑ Venereal Disease ❑ Other _____

Date of Last Menstrual Period_____ Date of PAP smear _____

Have you had a mammogram ❑ Yes ❑ No Date _____

CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

❑ AIDS ❑ Appendicitis ❑ Arthritis ❑ Asthma ❑ Bleeding Disorders ❑ Cancer ❑ Cataracts ❑ Chemical Dependent ❑ Chicken Pox ❑ Diabetes ❑ Emphysema ❑ Epilepsy ❑ Glaucoma ❑ Heart Disease ❑ Hepatitis ❑ Herpes ❑ High Cholesterol ❑ HIV Positive ❑ Kidney Disease ❑ Liver Disease ❑ Measles ❑ Migraine Headaches ❑ Multiple Sclerosis ❑ Mumps ❑ Pacemaker ❑ Pneumonia ❑ Polio ❑ Rheumatic Fever ❑ Scarlet Fever ❑ Stroke ❑ Thyroid Problems ❑ Tuberculosis ❑ Ulcers

Signatures

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or Personal Information.

_____

Signature of Patient/Parent or Guardian/Personal Representative Date

_____ _____

Printed name of Patient/Parent or Guardian/Personal Representative Relationship to Patient