MOUNTAINSTAR Healthcare

Lakeview OB / GYN
Gynecology and Women's Healthcare

Name: _____ DOB: _____
(First) (Last) (Maiden)

Father of Baby/Partner: _____ DOB: _____
(Last) (First)

Number to contact father in case of emergency: _____

How did you hear about us? Referred by: _____

OB/GYN History

How many times have you been pregnant? _____ How many live births?_____
How many miscarriages? _____ How many abortions? _____
First day of your last period? _____ Last pap smear? _____
Age at first period? _____ Any *abnormal* paps? _____
Any history of sexually transmitted infections? _____

1st baby date of birth: _____ 2nd baby date of birth: _____ 3rd baby date of birth: _____
Weeks at time of delivery: _____ Weeks at time of delivery: _____ Weeks at time of delivery: _____
Length of labor:_____ Length of labor:_____ Length of delivery:_____
Baby's weight:_____ Baby's weight:_____ Baby's weight:_____
Baby's sex:_____ Baby's sex:_____ Baby's sex:_____
Vagina or C-section:_____ Vaginal of C-section:_____ Vaginal or C-section:_____
Anesthesia: _____ Anesthesia:_____ Anesthesia:_____
Place of delivery:_____ Place of delivery:_____ Place of delivery:_____
Complications:_____ Complications:_____ Complications:_____

4th baby date of birth: _____ 5th baby date of birth: _____ 6th baby date of birth: _____
Weeks at time of delivery: _____ Weeks at time of delivery: _____ Weeks at time of delivery: _____
Length of labor:_____ Length of labor:_____ Length of delivery:_____
Baby's weight:_____ Baby's weight:_____ Baby's weight:_____
Baby's sex:_____ Baby's sex:_____ Baby's sex:_____
Vagina or C-section:_____ Vaginal of C-section:_____ Vaginal or C-section:_____
Anesthesia: _____ Anesthesia:_____ Anesthesia:_____
Place of delivery:_____ Place of delivery:_____ Place of delivery:_____
Complications:_____ Complications:_____ Complications:_____

Current Medications/Supplements/Vitamins

Name and dosage (Please continue on the back of page, if needed)

_____ _____
_____ _____

Social History

Any alcohol use? Yes___ No___ If yes, how many per occasion? _____
Any tobacco use? Yes___ No___ If yes, how many per occasion? _____
Any caffeine use? Yes___ No___ If yes, how many per occasion? _____
Any drug use? Yes___ No___ If yes, how many per occasion? _____
Any history of domestic / sexual violence? Yes___ No____

Surgical history
Year and type of surgery

_____ _____
_____

Family history (Any female family member, ie grandmother, mother, sister, aunt)
Breast cancer:_____ Cervical cancer:_____ Ovarian cancer:_____ Uterine cancer:_____
Colon cancer:_____ Other medical problems that run in the family:_____

Preferred pharmacy

_____

Preferred Lab
Lab:_____ I understand that I am responsible for providing the name of the laboratory my insurance required I use. Lakeview OB/GYN defaults to LABCORP

Medical History
Are you allergic to any medications? Yes___ No ___ If yes, please list: _____
Do you have any of the following conditions?

Cancer: _____	Heart Disease: _____	High Blood Pressure: _____
Asthma: _____	Bowel Disorder: _____	Stomach/Ulcer disease: _____
Diabetes: _____	Thyroid problems: _____	Kidney/Urinary disease: _____
Hepatitis: _____	Blood Clots, leg/lungs: _____	Seizure/Neurological disorder: _____

Genetic History
Is there any family history (mother or father) of any of the following conditions?

Down Syndrome: _____	Autism: _____	Cystic Fibrosis: _____	Mental Retardation: _____
Muscular Dystrophy:_____	Spina Bifida: _____	Thalassemia: _____	Other birth defects: _____

Other medical problems that run in family: _____

GENERAL CONSENT FOR CARE AND TREATEMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us the permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risk and benefit of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and or mid-level provider (nurse practitioner, physician assistant, or clinic nurse specialist), and other health care providers or the designees care at this practice. I understand that if additional testing, invasive or interventional procedures are recommend. I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____ Date:_____

Printed name of patient or personal representative:_____ Relation to patient:_____