PREMIER
OBSTETRICS & GYNECOLOGY

1307 8th Avenue Suite 403 P: (682) 207-1375
Fort Worth, TX 76104 F: (682) 207-1377

NEW PATIENT INTAKE FORM

A. Demographics

Name (Last, First)	Date of birth	Age
Home Address	City/Zip Code	Cell Phone/Home Phone
Employer		Work Number
Social Security Number		Spouse Name
Email address	Primary Care Physician	Spouse Phone
Preferred Pharmacy /Pharmacy Phone Number		

B. Billing and Insurance

Insurance Company Name	ID/Policy Number	Group Number
Insurance Company Address	Policyholder's DOB	
Policyholder's name	Phone Number	Relationship to patient

C. Menstrual History

1. Age at first period: _____ 2. If your menstrual periods are regular, periods start every _____ days
3. If your menstrual periods are irregular, periods start every ____ to _____ days
4. Duration of bleeding: _____ days 5. Does bleeding or spotting occur between periods? ☐Yes ☐No
6. Does bleeding or spotting occur after intercourse? ☐Yes ☐No
7. First day of last menstrual period _____(MM/DD/YY) ☐Menopause____(Age)
8. Is pain associated with periods? ☐Yes ☐No ☐Sometimes
9. If yes to #8, is it painful before menses? ☐during menses? ☐both?

D. Pregnancy History (including miscarriage, terminations, and ectopics)

Year	Weeks at birth (Ex: 39wks)	Type of delivery (Vaginal vs. C/S)	Weight of infant	Sex of infant	Place of delivery	Complications

E. Sexual History

1. Which birth control method do you currently use? _____
2. Are you currently sexually active? ☐Yes ☐No
3. Do you have a sexual partner? ☐Male ☐Female ☐Both

F. Past Gynecological History

1. Date of last pap smear: _____(MM/YY) 2. Have you had any abnormal pap smears? ☐Yes ☐No
3. Have you had treatment of abnormal pap smears? ☐Yes ☐No
   If yes, what type of treatment? _____
4. Date of last mammogram? _____(MM/YY)
5. Have you had an abnormal mammogram? ☐Yes ☐No
6. Have you ever had any of the following:

☐Chlamydia ☐Gonorrhea ☐Herpes ☐Venereal warts ☐Endometriosis
☐Pelvic inflammatory disease ☐Fibroids

***Please be advised, you will be required to complete this form at your first office visit of each year. The information that you provide is updated yearly and ensures we have accurate information to file a claim on your behalf. Thank you for your assistance with this process.

G. Past Medical History (Check any that apply)

☐Arthritis ☐Kidney Disease ☐Thyroid disease ☐Diabetes ☐Gallstones
☐Asthma ☐High Blood Pressure ☐Liver disease ☐Blood clots ☐Urinary incontinence
☐Heart disease ☐Blood transfusions ☐Other:_____
Date of last colonoscopy: _____(MM/YY) Date of last Flu Vaccine: _____(MM/YY)
Date of last DEXA scan: _____(MM/YY)

H. Surgery History

Year	Surgery performed

I: Current medications

Medication	Dose	Frequency

J: Social History

1. Do you currently smoke? ☐Yes ____(packs/day) ☐No ☐Former
2. Drink alcohol? ☐Yes (___glasses/day) ☐No 3. Use illicit drugs? ☐Yes (_____type) ☐No
4. Occupation? _____
5. Are you? ☐Married ☐Single ☐Significant other ☐Divorced ☐Widowed
6. Emergency contact name:_____ Phone #:_____

K: Drug Allergies

1. ☐Yes ☐No

Drug Name	Reaction (Ex: hives)

L: Family History (Please check all that apply)

	Alive	Deceased	Hypertension	Diabetes	Heart Disease	Ovarian Cancer	Uterine Cancer	Colon Cancer	Breast Cancer
Mother									
Father									
Brother									
Sister									
Grandparents									

M: Payment Policy

I, the undersigned, hereby authorize payment directly to Premier Obstetrics & Gynecology for medical services rendered. I understand I am financially responsible for all charges not covered or authorized by my insurance company. I also understand that I am liable for a $25.00 fee for not showing up to my scheduled appointment.

Printed Name: _____

Signature: _____ Date: _____

***Please be advised, you will be required to complete this form at your first office visit of each year. The information that you provide is updated yearly and ensures we have accurate information to file a claim on your behalf. Thank you for your assistance with this process.