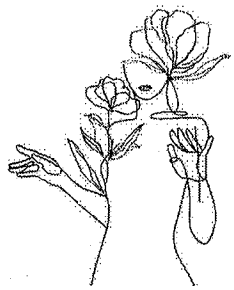
DR. GINGER W. CARTER, PLLC

Gynecology & Women's Health



OB/GYN MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Pharmacy Name & Address: _____

Primary Care Physician: _____

Social History:

Marital Status: SINGLE / ENGAGED / MARRIED / DIVORCED / WIDOWED

Occupation: _____ Spouse's Occupation (if applicable): _____

Do you smoke tobacco products? Never / Former-Quit_____ / Yes-Age Started: _____ How much per day? _____

How often do you drink alcohol? Never / Monthly or less / 2-4 times per month / 2+ times per week

Do you use illegal drugs? Never / Prior History / Current Use-Type & How often? _____

How much exercise do you get? None / 1-2 times per month / 1-2 times per week / 3-4 times per week / Daily

Do you currently or have you ever had any the following? (please circle all that apply)

Abnormal Pap Smear
Asthma
Blood Clot
If so, where? Were you on a blood thinner? _____
Blood Transfusion
Cancer
If so, what kind? _____
Chronic Bronchitis/Lung Disease
Colitis
Crohn's Disease
Diabetes
Diverticulitis/Diverticulosis
Epilepsy/Seizure Disorder
Heart Disease
Heart Valve Disease
Hepatitis: A B C
Herpes: Genital / Oral
High Blood Pressure
High Cholesterol
Irritable Bowel Syndrome
Liver Disease
Lupus
Kidney Disease
Kidney Stones
Migraines
Neurologic Disease
Osteoporosis
Peptic Ulcers
Polycystic Ovarian Syndrome
Sexually Transmitted Disease
Stroke
Thyroid Disease: Hypo / Hyper
Tuberculosis

Health Maintenance:

Please provide the **date and result** of your most recent:

- ✓ Pap Smear _____
- ✓ Mammogram _____
- ✓ Bone Density Scan _____
- ✓ Colonoscopy _____

Sexual History:

Have you had any sexual activity in the past 12 months? YES / NO

Have your sexual partners been: ☐ Male ☐ Female ☐ Both

Are you using any form of contraception? YES / NO If so, what method? _____

Review of Systems (please circle all that apply):

Anxiety	Easy Bleeding	Nipple Discharge
Blood in Urine	Excessive Thirst	Nosebleeds
Breast Pain	Fever	Painful Sex
Bruise Easily	Frequent Headaches	Rash
Blood in Stool	Genital Sores/Warts	Shortness of Breath
Change in Skin Moles	Hot Flashes	Urinary Incontinence
Chest Pain	Joint Pain	Urinary Frequency
Chills	Loss of Appetite	Vaginal Discharge
Constipation	Lower Leg Swelling	Vomiting
Depression	Nausea	Weight Loss/Gain
Diarrhea	Neck Pain	Wheezing
Difficulty Sleeping	Nighttime Urination	Wears Glasses/Contacts

Gynecologic History:

First day of your last period? ____/____/_____

Are your periods regular? YES / NO

How many days do your periods last? _____

Age at your first period? _____

Have you gone 12 consecutive months without a period? YES / NO

If yes, at what age did your periods stop? _____

Obstetric History:

Total number of pregnancies: _____

Full-term deliveries: _____

Miscarriage(s): _____

Abortion(s): _____

Ectopic pregnancies: _____

Number of living children: _____

Have you ever done fertility treatment? YES / NO

If yes, please explain: _____

Obstetric History (continued):

Date	Delivery (Vaginal or C-Section)	Weeks at Time of Delivery	Baby's Sex	Birth Weight	Doctor / Location of Delivery	Please list any complications:
	☐ V ☐ C		☐ M ☐ F			
	☐ V ☐ C		☐ M ☐ F			
	☐ V ☐ C		☐ M ☐ F			
	☐ V ☐ C		☐ M ☐ F			
	☐ V ☐ C		☐ M ☐ F			

Family History:

Are you adopted? YES / NO (if blood relative history unknown, skip this section)

Please indicate if a blood relative has been diagnosed with one of the following and specify relationship (for extended family, please specify maternal or paternal) and age of onset-

- ☐ Addiction/Alcoholism _____
- ☐ Asthma _____
- ☐ Bleeding Disorder _____
- ☐ Breast Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Colon Cancer _____
- ☐ Other Cancer (please explain) _____
- ☐ Diabetes _____
- ☐ Epilepsy/Seizures _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Kidney Disease _____
- ☐ Osteoporosis _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____

Do you have any family history of genetic or chromosomal disorders? YES / NO If yes, please explain:

Surgical History:

Please list ALL surgeries/procedures and the year they were performed. If none, please write none.

_____ _____

_____ _____

_____ _____

Allergies:

Please list ALL food/drug allergies and specify your reaction & severity below. If none, please write none.

_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe

Medications:

Please list ALL prescription and OTC medications you take regularly, along with the dosage:

Medication Name	*Dosage*	*Prescribing Physician*

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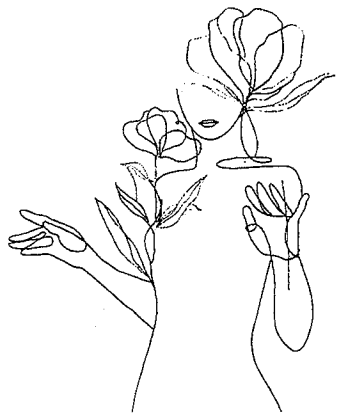

Patient Information Form

(please print)

First Name: _____ MI: _____ Last Name: _____

DOB: _____ SSN#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____ Occupation: _____

Responsible Party (if other than patient)

First: _____ Last: _____ DOB: _____

SSN#: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Have you seen Dr. Carter before? YES / NO

If no, where did you hear about us? _____

****PLEASE HAVE YOUR DRIVER'S LICENSE AND INSURANCE CARD(S) AVAILABLE TO COPY****

Dr. Ginger W. Carter, PLLC

Financial Payment Policy

Thank you for choosing Dr. Ginger W. Carter, PLLC as your healthcare provider. We are committed to your well-being and health. In an effort to ensure that patients are familiar with our payment policy, we provide this for your review. Please let us know if you have any questions or concerns.

Your insurance policy is between you and your insurance provider. You will want to be sure that Dr. Ginger W. Carter is a participating provider in your insurance plan before receiving care from us to avoid being personally responsible for the payment at the time of service. Also, any provided service not covered by your insurance is the responsibility of the patient.

By submitting your insurance information to us, you are giving us permission to bill your insurance on file. If your insurance situation changes, let us know as soon as possible to avoid unexpected charges.

Patients with third party insurance plans with whom we do not contract are responsible for payment in full at the time of service. We will provide you with the needed information for you to submit a claim to your insurance for your reimbursement (when applicable).

Co-pays and deductibles are due prior to treatment. If you are unable to pay the day of the service, you will be asked to reschedule your appointment. Any balances must be paid prior to scheduling appointments.

We gladly accept cash, check, and all major credit cards. There is a small convenience fee (no more than $3) for all credit card transactions. There is a $35 service fee for returned checks.

We want to be available for all of our patients. Please help us to serve every patient by keeping your scheduled appointments or cancelling an appointment 24 hours in advance to avoid a possible $35 missed appointment charge.

All of us with Dr. Ginger W. Carter, PLLC are committed to serving you in the most efficient manner possible, and we appreciate your assistance in these matters.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received my Notice of Privacy Practices from **Dr. Ginger W. Carter, PLLC** detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL PAYMENT POLICY

By signing below, I acknowledge that I have read, understand, and agree to abide by the payment policies of **Dr. Ginger W. Carter, PLLC.**

Signature:_____ Date: _____

PATIENT AUTHORIZATION REGARDING COMMUNICATION

We want to know how to get medical information to you. By placing your initials in the spaces below, you give your authorization to have your information relayed to you as follows:

_____ You may contact me at work: My work number is : _____

_____You may contact me on my cell phone. My number is: _____

_____You may leave message on : ____ cell phone _____home answering machine

_____You may text/email me appointment reminders, refills, etc:

My email address is: _____

You may also leave messages and/or discuss my medical care with the following:

Name of person_____ Relationship:_____

Name of person_____ Relationship:_____

Name of person_____Relationship:_____

I hereby release Dr. Ginger W. Carter, PLLC from any and all liability that may arise from the release of the information given or obtained using the methods above.

_____ _____

Signature Date