DR. GINGER W. CARTER, PLLC

Women's Health & Gynecology

Patient Information Form

(please print)

First Name: _____ MI: _____ Last Name: _____

DOB: _____SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

*Preferred phone contact number: _____

*Email Address: _____ Occupation: _____

*By providing this information, you consent to general appointment reminders being sent.

Policyholder of Insurance (if other than patient)

First Name: _____ Last Name: _____

Relationship to Patient: Mother / Father / Husband / Wife / Other: _____

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature acknowledges that ***Dr. Ginger W. Carter, PLLC*** makes available, at my request, a copy of its Privacy Notice, which explains how my personal health information (PHI) will be handled.

***Patient/Guarantor Signature**: _____ Date: _____

CONSENT for TREATMENT

Having voluntarily placed myself (or my dependent) under the care of ***Dr. Ginger W. Carter, PLLC***, I acknowledge that the evaluation and treatment received from ***Dr. Ginger W. Carter, PLLC*** is a mutual partnership between myself and its Physician.

***Patient/Guarantor Signature**: _____ Date: _____

ACKNOWLEDGMENT OF PERSONAL RESPONSIBILITY in OBTAINING MY TEST RESULTS

Dr. Ginger W. Carter, PLLC will make every effort to notify me of my test results in a timely fashion. I acknowledge that it is my ultimate responsibility to obtain my results. ***If test results are not reported to me, I cannot and will not assume that they are normal and/or stable.***

***Patient/Guarantor Signature**: _____ Date: _____

PATIENT AUTHORIZATION REGARDING COMMUNICATION

Dr. Ginger W. Carter, PLLC may communicate with me via email/phone/letter or other means at their discretion unless I specifically designate otherwise: _____

In addition, our office 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.

***Patient/Guarantor Signature**: _____ Date: _____

ACKNOWLEDGMENT OF FINANCIAL/LATE CANCELLATION/NO-SHOW POLICY

My signature acknowledges that I have read, understand, and agree to abide by this policy (found on our website and in office) of ***Dr. Ginger W. Carter, PLLC*** and understand the associated fees with this policy.

***Patient/Guarantor Signature**: _____ Date: _____

Dr. Ginger W. Carter, PLLC

Women's Health & Gynecology

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 use tobacco/vapes? 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 / 1-2x per month / 1-2x per week / 3-4 times per week / Daily

Do you currently or have you ever had any of 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
Chron's Disease
Depression
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 _____ ✓ Bone Density Scan _____

✓ Mammogram _____ ✓ 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/tubal/vasectomy? YES / NO If so, what method? _____

Review of Systems (please circle all that apply):

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

Gynecologic History:

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? _____
First Day of your last period? _____/_____/_____
Are your periods regular? YES / NO
How many days do your periods last? _____

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.

_____ _____

_____ _____

_____ _____

Medication: Please list ALL prescription and OTC medications you take regularly: If none, please write none.

Medication Name	*Dosage*	*Prescribing Physician*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Please list ALL food or drug allergies and specify your reaction and the severity below: If none, please write none.

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