Trinity Ob/Gyn

PATIENT INFORMATION **Date:**_____

NAME: _____/_____/_____
(Last) (First) (M.I.)
SSN:_____DOB:_____ GENDER:_____

ADDRESS: _____/_____/_____
(street or PO Box) (city & state) (zip)

PHONE: M:_____ H:_____W:_____
E-Mail_____

OCCUPATION_____EMPLOYER_____

ALLERGIES:_____
List ALL MEDICATIONS you take, including over-the-counter medications/vitamins.
_____

_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

Anemia	Crohn's Disease	High Blood Pressure
Anxiety	Ulcerative Colitis	High Cholesterol
Arrhythmia (irregular heart beat)	COPD/ Emphysema	HIV
	Depression	Hepatitis
Asthma	Diabetes	Irritable Bowel Syndrome
Bipolar	DVT (Blood Clot)/ Pulmonary Embolus	Lupus
Cancer: (type and year diagnosed)_____		Stroke
	GERD (Acid Reflux)	Thyroid Disorder
	Heart Disease	

Other Medical Problems_____
Last Menstrual Period_____(Normal or Abnormal)
Last Pap-smear _____(Normal or Abnormal)
Mammogram_____(Normal or Abnormal)
Colonoscopy_____(Normal or Abnormal)
Dexa (Bone Density)_____(Normal or Abnormal)

Trinity Ob/Gyn, PLLC

398 Copperfield Blvd NE
Concord, NC 28025

Ph: 704-262-3338
Fax: 704-706-3073

Please circle any of the following symptoms that apply:

Fatigue/low energy
Heat/cold intolerance
Urinary incontinence
Weight gain/difficulty losing weight
Vaginal dryness
Decreased libido/sexual desire
Difficulty sleeping
Hot flashes/Night sweats

Prior Surgery- Have you ever had: (circle all that apply and give approximate date)

Hysterectomy_____
Ovary removal_____
Bilateral Tubal Ligation_____
Appendectomy_____
Cholecystectomy(gallbladder)_____
Bowel surgery_____
Bladder surgery_____

Please list any other surgical procedures_____
How many pregnancies have you had?_____
How many vaginal deliveries?_____ cesarean deliveries_____

Social History-

Smoking/Tobacco use: ____current ____never ____past (type_____)
Alcohol use: ____current ____never ____past (drinks/week_____)
Recreational Drug use: ____current ____never ____past (type_____)

Family History: (list any important disease or issue with parents, grand-parents, or siblings)

_____
_____

Please list any other medical providers you see on a regular basis

_____
_____

Please list any other issues or concerns not addressed above

_____
_____

Primary Insurance Information:

Company_____ Subscribers name & DOB_____
Policy number_____ Group number_____
_____
(subscriber relationship to you if you are not main subscriber)
List any secondary insurance information:

_____
_____

Signature:_____ **Date:**_____