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

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)

**Please circle any of the following symptoms that apply**:

| | |
|---|---|
| Fatigue /low energy | Vaginal dryness |
| Heat/cold intolerance | Decreased libido/sexual desire |

**Trinity Ob/Gyn, PLLC**
**1028 Lee Ann Drive NE, Suite #100** **Ph: 704-262-3338**
**Concord, NC 28025** **Fax: 704-706-3073**

Urinary incontinence
Weight gain/difficulty losing weight
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:_____**