

Issaquah Obstetrics and Gynecology, PLLC

6520 226th PI SE
Issaquah, WA 98027
425 391-8886

PATIENT INFORMATION

Name:						
Last	First			MI		
Address:		City:	St:	Zip:	Birthdate(mm/dd/yyyy)	
Home Phone: ()	<input type="checkbox"/> OK to Leave Message	Cell Phone: ()	<input type="checkbox"/> OK to Leave Message	Work Phone: ()	<input type="checkbox"/> OK to Leave Message	Social Security Number
<input type="checkbox"/> Married Spouse/Partner Name:		<input type="checkbox"/> Single		<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	

PREFERRED LOCAL PHARMACY

Name:	Phone:
-------	--------

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:

Subscriber Name:			
Last	First	MI	
Subscriber's Soc Sec Number:	Subscriber's Birthdate:	Relationship to Patient :	Sex of Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> Female

SECONDARY INSURANCE NAME:

Subscriber Name:			
Last	First	MI	
Subscriber's Soc Sec Number:	Subscriber's Birthdate:	Relationship to Patient :	Sex of Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> Female

REFERRAL INFORMATION

Referred by:
<input type="checkbox"/> Insurance <input type="checkbox"/> Dr. _____ <input type="checkbox"/> ER <input type="checkbox"/> Friend _____ <input type="checkbox"/> Other _____

EMPLOYMENT INFORMATION

Employer Name:		Occupation:			
Address:	City:	St:	Zip:	Employer Phone:	

EMERGENCY INFORMATION

Name:	Relationship to Patient:
Phone: ()	Alternate Phone: ()

RELEASE OF BENEFITS AND INFORMATION

Office Policies:
1. Any Co-pay not collected at time of service will be assessed a \$10.00 service fee.
2. Completion of forms (adoption papers, disability, jury letters, etc) will be assessed a \$25.00 service fee

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify your office of any and all changes to the above information. I authorize Issaquah Obstetrics and Gynecology to release any information required to process my claims with my insurance company.

Signature:	Date:
Parent (if minor):	Date:

Issaquah Obstetrics & Gynecology, PLLC

HEALTH HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____

Birth Date: _____ Today's Date: _____

What name do you wish to be called? _____

Previous Hospitalizations, Surgery, Serious Injury

Type	Year
_____	_____
_____	_____
_____	_____

Date of last pap _____

First day of last menstrual period _____

Usual interval between periods _____

How long do your periods last _____

Current Medications

Name	Dose
_____	_____
_____	_____
_____	_____

Are your periods painful Yes No

Is there bleeding between periods Yes No

Number of pregnancies _____

Number of children _____

Have you had difficulty becoming pregnant Yes No

Do you use any birth control method Yes No

If so, what type _____

List other forms you have used _____

Are you satisfied with your birth control Yes No

Is there any aspect of your sexuality or a problem you wish to discuss Yes No

Do you have any abnormal vaginal discharge Yes No

Have you had an infection in your tubes or ovaries Yes No

Have you ever had an abnormal pap smear Yes No

Have you ever had genital warts Yes No

Have you ever had genital herpes Yes No

Drug Allergies Yes No

Past or Present Illness

Diabetes	Yes	No
Thyroid	Yes	No
High blood pressure	Yes	No
Heart disease or murmur	Yes	No
Migraine headaches	Yes	No
Respiratory problems/Asthma	Yes	No
Stomach or bowel problems	Yes	No
Hepatitis	Yes	No
Blood transfusions	Yes	No
Bladder infections	Yes	No
Uncontrolled loss of urine	Yes	No
Easy bruising / nosebleeds / bleeding disorders	Yes	No
Deep vein thrombosis	Yes	No
Pulmonary embolus	Yes	No

Family History

Diabetes	_____
Heart disease	_____
High blood pressure	_____
Genital cancer	_____
Breast cancer	_____
Bleeding problems	_____
Multiple births (twin, triplets)	_____
Birth defects or hereditary disease	_____

Relation to You

Non-prescription drugs	Yes	No
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Use

Cigarettes	Yes	No	Amt/Day	_____
Alcohol	Yes	No	Amt/Day	_____
Caffeine	Yes	No	Amt/Day	_____

Do you prefer to have a nurse present when the doctor examines you? Yes No