St. Joseph's Health
Passaic Valley ObGyn

1225 McBride Ave, Suite 220, Woodland Park, NJ 07424
TEL: 973-569-6380 FAX: 973-790-1143

A DEMOGRAPHICS

How were you referred to us? _____

Name: _____ Date of Birth: _____

Email address: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security No.: _____ Ethnicity: _____ Race: _____

Preferred Language: _____ Occupation: _____

Work Address: _____

Work Phone No.: _____

Primary care physician: _____

Emergency Contact Name: _____ Phone No.: _____

Primary Insurance: _____ ID No.: _____ Group: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder Relation: (circle one) Self / Spouse / Dependent

Secondary Insurance: _____ ID No._: _____ Group: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder Relation: (circle one) Self / Spouse / Dependent

Preferred Pharmacy: _____ Phone number: _____

Address: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to this office for services rendered. I understand I am financially responsible for any balance not covered by my insurance.

Signature_____Date_____

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Patient Medical History

B GYN HISTORY

Age at first period: _____

Periods are: □ Regular □ Irregular Frequency: Every _____ days

Duration of flow: _____ days Flow: □ Heavy □ Normal □ Light

Have you had abnormal PAP tests: □ Yes □ No Date of last PAP: _____

If YES, have you ever had: □ Colposcopy □ Cryotherapy □ LEEP □ Cone biopsy

Have you had abnormal MAMMOGRAM: □ Yes □ No

If YES, have you ever had: □ Biopsy □ Lumpectomy/Mass excision

Date of last mammogram: _____

Have you ever had any sexually transmitted infections: □ Yes □ No

□ HPV □ Syphyllis □ Chlamydia □ Gonorrhea □ Hepatitis B □ Hepatitis C

□ Genital Warts □ Genital Herpes □ HIV/AIDS □ Pelvic inflammatory disease (PID)

Have you been told you have: □ Fibroids □ Ovarian cysts □ PCOS □ Endometriosis

Have you received the HPV vaccine (Gardasil)? □ Yes □ No Date: _____

Have you ever been sexually active: □ Yes □ No

Are you currently sexually active: □ Yes □ No

If YES, are you sexually active with : □ Men □ Women □ Both

Do you consider yourself: □ Heterosexual □ Homosexual □ Bisexual

Do you currently use birth control: □ Yes □ No

If YES, which type: _____

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C PREGNANCY DELIVERY HISTORY □ Never been pregnant

Date	# Weeks	Delivery Type	Hospital	Complications	Name	Sex	Weight	Health Issues

**Delivery type = vaginal, c-section, vacuum, forceps

PREGNANCY LOSS HISTORY

Date	#Weeks	Type	Treatment	Complications
		□Miscarriage □Abortion □Tubal/Ectopic	□Medical □Surgical □None	
		□Miscarriage □Abortion □Tubal/Ectopic	□Medical □Surgical □None	
		□Miscarriage □Abortion □Tubal/Ectopic	□Medical □Surgical □None	
		□Miscarriage □Abortion □Tubal/Ectopic	□Medical □Surgical □None	
		□Miscarriage □Abortion □Tubal/Ectopic	□Medical □Surgical □None	

D MEDICAL HISTORY

Do you have problems with, or been diagnosed with, any of the following:

NEUROLOGIC

□ Seizures □ Migraines □ Multiple sclerosis □ Fibromyalgia

ENDOCRINE

□ Hyperthyroidism □ Hypothyroidism □ Diabetes □ Osteoporosis □ Osteopenia

ORTHOPEDIC

□ Herniated disc □ Scoliosis □ Previous fracture □ Osteoarthritis

CARDIOVASCULAR

□ High blood pressure □ Coronary artery disease □ Congestive heart failure □ Blood clot (lung/leg)

□ Mitral valve disease □ Aortic valve disease

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PULMONARY

□ Asthma □ Tuberculosis □ COPD

GASTROINTESTINAL

□ Acid reflux (GERD) □ Ulcers □ Gallstones □ Hepatitis □ Irritable bowel syndrome (IBS)

□ Colitis (Crohn's Disease/Ulcerative Colitis) □ Diverticulosis

UROLOGIC

□ Kidney stones □ Recurrent UTI □ Urinary incontinence

AUTOIMMUNE

□ Lupus □ Sjogren's □ Rheumatoid arthritis

PSYCHIATRIC

□ Depression □ Postpartum depression □ Anxiety □ Bipolar disorder □ Prior suicide attempt

□ Anorexia □ Bulemia

CANCER

□ Breast □ Colon □ Leukemia □ Lymphoma □ Cervix □ Uterus □ Ovaries □ Other: _____

OTHER: _____

E SURGICAL HISTORY

Have you ever had problems with anesthesia: □ Yes □ No

Have you ever required a blood transfusion: □ Yes □ No

Would you accept a transfusion in a life-threatening emergency: □ Yes □ No

Have you had any of the following:

□ Hysteroscopy Date: _____ □ D&C Date: _____

□ Laparoscopy Date: _____ □ Ovary cyst removal Date: _____

□ Ovary removal Date: _____ □ Myomectomy Date: _____

□ Hysterectomy Date: _____ □ Tubes tied Date: _____

□ Bladder lift Date: _____ □ C-section Date: _____

□ LEEP/Cone Date: _____ □ Cerclage Date: _____

□ Gallbladder removal Date: _____ □ Appendectomy Date: _____

□ Bariatric surgery; Type: _____

□ Plastic surgery; Type: _____

□ Other; Type: _____

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F SOCIAL HISTORY

Do you smoke cigarettes: □ Yes □ No If YES, # packs per day: _____

Do you drink alcohol: □ Yes □ No If YES, how often: _____

Do you use other drugs: □ Yes □ No If YES, what type: _____

Occupation: _____

G FAMILY HISTORY

Include parents, siblings, children, aunts, uncles, and first cousins only

□ Breast cancer Who: _____

□ Colon cancer Who: _____

□ Uterus cancer Who: _____

□ Cervix cancer Who: _____

□ Ovarian cancer Who: _____

□ Diabetes Who: _____

□ Heart disease Who: _____

□ Blood clots Who: _____

□ Other significant medical issues: _____

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H CURRENT MEDICATIONS / ALLERGIES

Do you have a LATEX allergy: □ Yes □ No Reaction: _____

Do you have seasonal allergies: Yes □ No

Medication Allergies

Medication	Reaction

Current Medications

Medication	Dose	Frequency

What is the reason for your visit today? _____

Please list and concerns you would like to discuss with the doctor: _____

_____

_____