

# Dr. Gwynn Patterson M.D., F.A.C.O.G.

Obstetrics and Gynecology, Aesthetics and Laser

4990 E Mediterranean Dr. Suite C

Sierra Vista, AZ 85635

Last Name:			First Name:			Middle Name:		
Address:			City:		State:		Zip Code:	
Home #:			Cell #:		E-mail:			
Social Security #:			DOB:			Marital Status:		
Patient's Race:		Ethnicity:		Declined to specify				
Pharmacy:			Family Doctor:					
Emergency Contact:		Relationship:		Phone:				
<b>Insurance Information</b> <b>Please note you are responsible for knowing your insurance policies along with any copays and deductibles. Copays are due at time of service.</b>								
Primary Insurance:				ID#:		Group#:		
Insured's name:				Insured's Date of Birth:				
Insured's Social Security #:				Insured's relationship to Patient:				
Secondary Insurance:				ID#:		Group#:		
Insured's name:				Insured's Date of Birth:				
Insured's Social Security #:				Insured's relationship to Patient:				

Do you have a Living WILL? YES NO

**No Show/ Cancellation Policy:** You must give us 24hrs notice to cancel an appointment. If you no show for an appointment we will send you a letter and a bill for \$50. Excessive No Shows/Cancellations and we will dismiss you from the practice.

**Notice of Privacy Practice:** A copy of the privacy practice is located in the office and offered to you based on the Health Insurance Portability and Accountability Act.

Please understand that this is an OB/GYN office and deliveries can upset the schedule. We do our best to give you sufficient notice if we need to re-schedule your appointment.

Children need to be in car seats or strollers.

Specimens are sent to an outside lab. Please make sure your insurance is contracted with the lab it is going to, you may get a bill from them.

Regarding all labs and pap smear results don't assume no news is good news. You can log onto the website of whatever lab you went to in order to get results. Pap smear results will be mailed to you, if for some reason you don't get it please call us.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# FAMILY HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Breast Cancer:  yes  no Maternal ONLY: Who:  mother  sister  maternal aunt  maternal grandmother

Uterine Cancer:  yes  no Maternal ONLY: Who:  mother  sister  maternal aunt  maternal grandmother

Ovarian Cancer:  yes  no Maternal ONLY: Who:  mother  sister  maternal aunt  maternal grandmother

Colon Cancer  yes  no  mother  father  siblings

Diabetes  yes  no  mother  father  siblings

Heart Disease  mother  father  siblings

Osteoporosis  yes  no In mother  yes  no

Thrombosis (clots in legs)  yes  no  mother  father  siblings

Pulmonary Embolism (clot in lungs)  yes  no  mother  father  siblings

Positive family history of high cholesterol  yes  no  mother  father  siblings

Mother:  Living  Deceased Cause of death: \_\_\_\_\_ Father:  Living  Deceased Cause of death: \_\_\_\_\_

Siblings: number living \_\_\_\_\_ number deceased \_\_\_\_\_

Causes of death: \_\_\_\_\_

## SOCIAL HISTORY

Profession: \_\_\_\_\_

Tobacco use:  yes  no \_\_\_\_\_ packs per day \_\_\_\_\_ cigarettes per day

Alcohol use:  yes  no \_\_\_\_\_ drinks per day \_\_\_\_\_ drinks per week \_\_\_\_\_ rarely

Recovering alcoholic:  yes  no

Illegal drugs:  yes  no

Domestic violence:  yes  no

Seat belt use:  yes  no

## SEXUAL HISTORY

Are you a virgin?  yes  no Have you had oral sex?  yes  no

Are you sexually active?  yes  no If no, how long NOT active? \_\_\_\_\_

New sexual partners in the past 6 - 12 months?  yes  no

Heterosexual (man & woman)  yes  no Homosexual (same sex)  yes  no Bisexual (both men & women)  yes  no

Exercise:  yes  no

Walking:  yes  no How many miles: 1 2 3 4 5 x per week 1 2 3 4 5 6 7

Hiking:  yes  no How many miles: 1 2 3 4 5 x per week 1 2 3 4 5 6 7

Bike riding:  yes  no How many miles: 1 2 3 4 5 x per week 12 3 4 5 6 7

Weightlifting:  yes  no 5 10 15 20 lbs x per week 1 2 3 4 5 6 7

Gym:  yes  no x per week 1 2 3 4 5 6 7

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEW OF SYSTEMS (ROS)

Problem Pertinent ROS = Positive & pertinent responses related to problem 99203 and 99213

Extended ROS = Positive & pertinent responses for 2-9 systems 99204 and 99214

Complete ROS = Positive & pertinent responses for at least 10 systems 99205 and 99215

**IF YOU DO NOT HAVE ANY OF THE FOLLOWING PROBLEMS, PLEASE MARK THE NO PROBLEM BOX FOR ALL QUESTIONS.**

1. Constitutional  No problem  Weight loss  Weight gain  Fever  Fatigue / tiredness

2. Eyes  No problem  Vision change  Glasses / contacts

3. ENT/Mouth  No problem  Lesions on the face  Inflammation of sinuses  Ringing in the ears  
 Headache  Other \_\_\_\_\_

4. Cardiovascular  No problem  Discomfort with breathing  Chest pain  Swelling

5. Respiratory  No problem  Wheezing  Spitting up blood  Shortness of breath  Cough  
 Other \_\_\_\_\_

6. Gastrointestinal  No problem  Diarrhea  Bloody stool  Nausea and vomiting  Constipation  
 Flatulence  Pain with bowel movement  Other \_\_\_\_\_

7. Genitourinary  No problem  Blood in urine  Pain with urination  Urgency  Frequency  
 Incomplete emptying  Incontinent (unable to make it to restroom on time)  
 Abnormal bleeding  Pain with intercourse  Other \_\_\_\_\_

8. Musculoskeletal  No problem  Muscle weakness  
 Other \_\_\_\_\_

9. Skin/Breast  No problems  Painful breasts  Discharge from the nipples  Breast lumps  Rash  
 Skin lesions  Other \_\_\_\_\_

10. Neurological  No problem  Fainting spells  Seizures  Numbness  Trouble walking  
 Other \_\_\_\_\_

11. Psychiatric  No problem  Depression  Crying  
 Other \_\_\_\_\_

12. Endocrine  No problem  Diabetes  Overactive thyroid  Underactive thyroid  Hot flashes  
 Other \_\_\_\_\_

13. Hemat/Lymph  No problem  Bruise easily  Bleeding easily  Swelling of the lymph nodes  
 Other \_\_\_\_\_

**NAME:**  
**DATE OF BIRTH:**

**DATE:**

## **Incontinence Questionnaire**

Please answer as accurately as possible.

1. Do you leak urine when you cough, sneeze, or laugh? **Yes / No**
2. Do you ever have such an uncomfortably strong need to urinate that if you reach the toilet you will leak? **Yes / No**
3. If “yes” to No. 2, do you ever leak before you reach the toilet? **Yes / No**
4. How many times during the day do you urinate?
5. How many times do you void during the night after going to bed?
6. Have you wet the bed in the past year? **Yes / No**
7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? **Yes / No**
8. Do you ever leak during or after sexual intercourse? **Yes / No**
9. Do you find it necessary to wear a pad because of your leaking? **Yes / No**
10. How often do you leak (times per day)?
11. Have you had bladder, urine, or kidney infections? **Yes / No**
12. Are you troubled by pain or discomfort when you urinate? **Yes / No**
13. Have you had blood in your urine? **Yes / No**
14. Do you find it hard to begin urinating? **Yes / No**
15. Do you have a slow urinary stream? **Yes / No**
16. Do you have to strain to pass your urine? **Yes / No**
17. After you urinate, do you have dribbling or a feeling that your bladder is still full?  
**Yes / No**

## What Concerns You?

Check off the particular concerns you would be interested in learning about solutions to:

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Wrinkles     | <input type="checkbox"/> Facial Veins (we don't treat leg veins) |
| <input type="checkbox"/> Blotchy Skin | <input type="checkbox"/> Brown and red spots                     |
| <input type="checkbox"/> Frown Lines  | <input type="checkbox"/> Droopy Eyes                             |
| <input type="checkbox"/> Turkey Neck  | <input type="checkbox"/> Excess Hair                             |
| <input type="checkbox"/> Crepe Skin   | <input type="checkbox"/> Sagging Face/Neck                       |
| <input type="checkbox"/> Acne         |  |

Other concerns you have questions about: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would You be interested in receiving e-mails from our office regarding our aesthetic services, promotions, etc?

YES      EMAIL: \_\_\_\_\_      NO

