



LEE OBSTETRICS & GYNECOLOGY

NEW PATIENT FORM

All new patients should complete this form, save as a PDF and email to registration@leeobgyn.com. Please include a copy of your driver's license and the front and back of your insurance card. Failure to supply your insurance policy information will result in your appointment being classified as a self-pay appointment which requires a \$150 deposit in order to be seen.

Patient Information:

Last Name _____ First Name _____ MI _____

Date of Birth _____ Social Security _____

Street Address _____

City _____ State _____ Zip _____

Email address _____ Cell Phone _____

Primary Insurance Name _____

Name of Insured _____ Insured Date of Birth _____

Policy Number _____ Group Number _____

Place of Employment: _____

Type of Work: _____

Any heavy lifting or strenuous activity associated with your position? Yes No (if "yes" describe below)

Gynecological History

When was your last Pap Smear: _____ (date)

Do you have a history of any abnormal pap smears? Yes No

Have you ever had any of the following procedures performed on you cervix?

___ Colposcopy _____ (date)

___ LEEP _____ (date)

___ Cold Knife Conization _____ (date)

Do you have a history of any sexually transmitted diseases?

Herpes Virus (1 or 2) Chlamydia Gonorrhea Syphilis HIV

Social History

___ Single ___ Married ___ Divorced ___ Separated ___ Engaged

Do you currently use tobacco in any form? Yes No If yes, how much per day _____

Have you recently quit using tobacco? Yes No If yes, how long has it been since you quit? _____

Do you currently drink alcohol in any form? Yes No If yes, how much per day _____

Do you currently use any drugs in any form? Yes No If yes, how much per day _____

Reason for Your Visit (check one)

Gynecological Visit – complete page 2 only

Obstetrical Visit – complete pages 3-6



For a Gynecological Visit – Please complete page 2 only

Describe the reason for your visit: _____

Medication History:

Please list any medications you are currently taking:

Name of medications (include dose & directions)

Medical/Surgical History:

Please list any chronic illnesses and any previous surgeries.

Date of your last Mammogram: _____ Location: _____

If you are transferring from another office, provide the following information:

Name of Practice/Provider: _____

Practice Address: _____

Phone Number: _____

Is there anything else our providers need to know about you to provide for your care: _____



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For an Obstetrical Visit – Please complete pages 3-6 only

Medical History:

Have you ever had Chicken Pox or had the vaccine? Yes No

Do you have or have you been diagnosed with any of the following medical problems?

- | | | | |
|----------------------------------------------|------------------------------------------------------------|-------------------------------------------|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Blood Clots
(in legs or lungs) | | |

If you checked any of the above problems or have any other chronic (longstanding) medical problems, please list and describe in detail below: _____

Medications:

Do you currently take any prescription or non-prescription medications including herbal supplements?

Yes No (if “yes” list below)

Medication	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken any prescription or non-prescription medications including herbal supplements for more than two weeks?

Yes No (if “yes” list below)

Medication	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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Allergies

Are you allergic to Latex? Yes No

Are you allergic to any medications? Yes No

Medication	Year of reaction	Reaction to medication
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

Surgical History

Have you ever had any surgery? Yes No (if "yes" describe below)

Surgery	Date performed	Name of Surgeon
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

Obstetrical History

Please list all pregnancies below including any miscarriages or abortions.

Date	Vaginal/C-Section	Male/Female	Weight	Delivering Physician and Location
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----

Check here if additional pregnancies are listed on the back of this page

Did you use fertility medication to conceive? Yes No

Were you under the care of a Reproductive Specialist? Yes No

Pregnancy Complications or Significant Events

During Pregnancy: Please check below if any of the following occurred during any of your pregnancies.

- | | |
|-----------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Delivery before 37 weeks |
| <input type="checkbox"/> Water breaks before 37 weeks | <input type="checkbox"/> Bleeding after 20 weeks |
| <input type="checkbox"/> Regular contractions before 37 weeks | <input type="checkbox"/> Diabetes (diet or medication controlled) |
| <input type="checkbox"/> Cerclage placement | <input type="checkbox"/> Growth problems with the baby |
| <input type="checkbox"/> Referral to high-risk OB/GYN (UAB) | <input type="checkbox"/> Medical need for more than 2 ultrasounds |
| <input type="checkbox"/> Genetic or structural issues with the baby | <input type="checkbox"/> Problems with the placenta |
| <input type="checkbox"/> Excessive vomiting requiring hospitalization | <input type="checkbox"/> Admission to hospital during pregnancy |
| <input type="checkbox"/> Fetal Death/Stillbirth | <input type="checkbox"/> Infections or severe illnesses |

If you checked any of the above complications or experienced any additional issues during your pregnancies, please describe in detail below:

During Delivery: Please check below if any of the following occurred during the delivery of your baby:

- | | |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Forceps or vacuum delivery | <input type="checkbox"/> Large vaginal tear (3 rd or 4 th degree) |
| <input type="checkbox"/> Anesthesia complications | <input type="checkbox"/> Fetal macrosomia (baby larger than 9 lbs) |
| <input type="checkbox"/> Problems with delivering baby's shoulders | <input type="checkbox"/> Large amount of bleeding |
| <input type="checkbox"/> Need for blood transfusion | <input type="checkbox"/> Abnormal or worrisome fetal heart tracing |
| <input type="checkbox"/> Need for antibiotics | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Placental abruption | <input type="checkbox"/> Need for Magnesium infusion |

If you checked any of the above complications or experienced any additional issues during your delivery, please describe in detail below:

After Delivery: Please check below if any of the following occurred after the delivery of your baby

- | | |
|-------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Large amount of bleeding | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Heart issues |
| <input type="checkbox"/> Need for blood transfusion | <input type="checkbox"/> Need for readmission to hospital |
| <input type="checkbox"/> Blood Clots in legs or lungs | |

If you checked any of the above complications or experienced any additional issues after your delivery, please describe in detail below:

Family History

Does your or your husband's (partner's) family have a history of any of the following abnormalities or other genetic disorders or birth defects?

- | | |
|------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Canavan Disease |
| <input type="checkbox"/> Duchenne Muscular Dystrophy | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Cardiac (Heart) Defects | <input type="checkbox"/> Neural Tube Defects |
| <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Phenylketonuria |
| <input type="checkbox"/> Polycystic Kidney Disease | <input type="checkbox"/> Tay-Sachs Disease |
| <input type="checkbox"/> Turner Syndrome | |

If you checked any of the above abnormalities or additional issues, please describe in detail below:

Additional Information:

Please list any additional information below that you feel we need to know in order to help us take care of you during your pregnancy:
