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)

Number of pregnancies you've had:
___ Number delivered full term
___ Number delivered preterm
___ Number of miscarriages
___ Number of living children

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: ____

Date of your last Pap Smear: ___________ 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?

___ High Blood Pressure
___ Stroke
___ Anemia
___ Back Pain
___ Diabetes
___ Swelling
___ Sickle Cell
___ Blood Clots (in legs or lungs)
___ Asthma
___ Kidney Disorders
___ Heart Condition
___ Chest Pain
___ Lupus
___ Chronic Pain

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.

___ High blood pressure

___ Water breaks before 37 weeks

___ Regular contractions before 37 weeks

___ Cerclage placement

___ Referral to high-risk OB/GYN (UAB)

___ Genetic or structural issues with the baby

___ Excessive vomiting requiring hospitalization

___ Fetal Death/Stillbirth

___ Delivery before 37 weeks

___ Bleeding after 20 weeks

___ Diabetes (diet or medication controlled)

___ Growth problems with the baby

___ Medical need for more than 2 ultrasounds

___ Problems with the placenta

___ Admission to hospital during pregnancy

___ 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:

___ Forceps or vacuum delivery

___ Anesthesia complications

___ Problems with delivering baby's shoulders

___ Need for blood transfusion

___ Need for antibiotics

___ Placental abruption

___ Large vaginal tear (3rd or 4th degree)

___ Fetal macrosomia (baby larger than 9 lbs)

___ Large amount of bleeding

___ Abnormal or worrisome fetal heart tracing

___ Seizure

___ 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:

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____

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

___ Large amount of bleeding

___ Depression

___ Infection

___ Need for blood transfusion

___ Blood Clots in legs or lungs

___ High blood pressure

___ Seizure

___ Heart issues

___ Need for readmission to hospital

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?

___ Mental Retardation

___ Down's Syndrome

___ Duchenne Muscular Dystrophy

___ Cardiac (Heart) Defects

___ Neurofibromatosis

___ Polycystic Kidney Disease

___ Turner Syndrome

___ Cystic Fibrosis

___ Canavan Disease

___ Hemophilia

___ Neural Tube Defects

___ Phenylketonuria

___ Tay-Sachs Disease

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

____
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____
____
____
____
____
____