Please complete this form and:

❒ Bring it to your appointment
❒ Mail it in the enclosed envelope
❒ Fax it to: (423) 875-8510 at least one day before your appointment.

North Park OB-GYN Associated, PC

Today's date: _____/_____/_____

Name _____ Preferred Name _____

Address _____

Birthdate _____/_____/_____ Social Security Number _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Primary Physician _____ Partner's Name _____

Reason for Visit: ❒ Routine Annual Exam ❒ Problem

Describe Problem _____

CHECK IF YOU HAVE HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST & LIST DATE:

❒ Anemia _____
❒ Anxiety _____
❒ Arthritis/Joint Pain _____
❒ Asthma _____
❒ Blood Transfusions _____
❒ Bowel Trouble _____
❒ Breast Cancer _____
❒ Cancer _____
❒ Chicken Pox _____
❒ Chlamydia _____
❒ Chronic Lung Disease _____
❒ Depression _____
❒ Diabetes _____
❒ Eating Disorder _____
❒ Fracture _____
❒ Glaucoma _____
❒ Gonorrhea / GC _____
❒ Heart Murmur _____
❒ Heart Trouble _____
❒ Hepatitis/Jaundice _____
❒ Herpes/HSV _____
❒ High Blood Pressure _____
❒ High Cholesterol _____
❒ HIV/AIDS _____
❒ HPV/Human Papilloma Virus _____
❒ Kidney Infection _____
❒ Urinary Tract Infect. _____
❒ Kidney Stones _____
❒ Mood Disorders _____
❒ Pneumonia _____
❒ Rheumatic Fever _____
❒ Sexually Transmitted Diseases _____
❒ Stroke _____
❒ Syphilis _____
❒ Tuberculosis - TB _____
❒ Thyroid Disease _____
❒ Ulcers _____
❒ Other: _____

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

Surgery/Hospitalization/Reason	Date

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

❒ Bone Density ..... Date _____
❒ Colonoscopy / Sigmoidoscopy ..... Date _____
❒ Mammogram ..... Date _____
❒ Last Normal PAP Smear ..... Date _____
❒ Last Abnormal PAP Smear ..... Date _____