

Well Balance Center

1110 East Austin St.
Paris, Texas 75460
Phone: (903) 785-6156
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Female Patient Information

Name: _____
First Middle Last Name Used

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

E-mail address: _____

Employed By: _____

Marital Status: Married Divorced Single Widow Living With Sig.

Spouse's Name: _____
First Last

Spouse's Date of Birth: _____ Social Security #: _____

Spouse's Employer: _____ Business Phone: _____

In case of an emergency, whom should we notify? _____

Do you have a Family Doctor? _____

Phone number(s): _____

Thank you for selecting Dr. Zimmerman for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience we accept Visa, MasterCard, cash and checks.

I AGREE THAT SHOULD THIS ACCOUNT BE REFERRED TO AN AGENCY OR AN ATTORNEY FOR COLLECTION I WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS, ATTORNEY'S FEES AND COURT COSTS.

Signature: _____ Date: _____

OB HISTORY

1. How many times have you been pregnant? _____

2. How many live births have you had?
3. How many children do you have?
-

GYN HISTORY

1. Are you sexually active? YES NO
- 1a. Have you been sexually active? YES NO
2. Do you have pain with intercourse? YES NO
3. What type of contraception are you currently using? (Circle below)
- | | | | | | |
|-------|----------------|-----------|------------|--------------|-----|
| Pills | Tubal Ligation | Condoms | Withdrawal | Depo Provera | IUD |
| Foam | Vasectomy | Diaphragm | Implants | Other _____ | |
4. What type of contraception have you used in the past? (circle below)
- | | | | | | |
|-------|----------------|-----------|------------|--------------|-----|
| Pills | Tubal Ligation | Condoms | Withdrawal | Depo Provera | IUD |
| Foam | Vasectomy | Diaphragm | Implants | Other _____ | |
5. Are you having any problems with your method of Birth Control? YES NO
6. Have you ever had any vaginal, cervical and/or Tubal infection? YES NO
- If yes, please check below:
- | | | | | | |
|---------------------------------|--------------------------------------|------------------------------------|------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Yeast | <input type="checkbox"/> Gardnerella | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Condyloma | <input type="checkbox"/> PID | <input type="checkbox"/> Bacterial Vaginitis |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Warts | <input type="checkbox"/> Other _____ |
7. Date of last pap smear? _____
8. Have you ever had an abnormal pap smear? YES NO
- If yes, how was it treated? Please check below:
- | | | | |
|---|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Repeated Pap Smear | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Cone Biopsy |
| <input type="checkbox"/> Cryosurgery (freezing) | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Loop Excision | |
9. Do you have any breast lumps, tenderness or discharge? YES NO
10. Do you do breast self-exams? YES NO
11. Do you have PMS symptoms? YES NO
- If yes, any treatment? _____
12. Do you have any hot flashes or menopausal symptoms? YES NO
13. Do you have any uterine anomalies? YES NO
14. Do you have a history of infertility? YES NO
15. Do you have a history of DES exposure? YES NO
-

MENSTRUAL HISTORY

1. If you no longer have periods, please state why: _____
2. Are your periods regular? YES NO
3. Do you have any bleeding between periods? YES NO
4. Do you have any cramping with your periods? YES NO
- If yes, circle one: mild moderate Severe
5. Medicine taken for cramps? _____
-

SOCIAL HISTORY

1. Do you smoke cigarettes/smokeless tobacco/dip/chew? YES NO
- If yes, how many per day? _____ # of years? _____
2. Do you use street drugs? YES NO
- If yes, which ones? _____
3. Do you drink alcohol? YES NO
- If yes, how much per day? _____
-

PAST MEDICAL HISTORY

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> hypertension |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> heart murmur |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> mitral valve prolapse |
| <input type="checkbox"/> urinary tract infection | <input type="checkbox"/> hepatitis/liver disease |
| <input type="checkbox"/> varicosities/phlebitis | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> major accidents | <input type="checkbox"/> blood transfusions |
| <input type="checkbox"/> asthma/lung disease | <input type="checkbox"/> lupus/arthritis |

1. Do you have any Drug Allergies?

If yes, please list: _____

2. Please list any GYN surgeries: _____

3. Please list any other operations/hospitalizations (include year & reason): _____

4. Have you ever been anemic? YES NO

5. Are you currently on any medications YES NO

If yes, please list with dosage: _____

6. Have you had your cholesterol checked? YES NO

7. Do you have Lupus, Scleroderma, or similar diseases/arthritis? YES NO

FAMILY HISTORY

1. Do you have a family history of breast cancer? YES NO

If yes, whom? _____

2. Do you have a family history of colon cancer? YES NO

If yes, whom? _____

3. Do you have a family history of ovarian cancer? YES NO

If yes, whom? _____

4. Do you have a family history of osteoporosis? YES NO

If yes, whom? _____

5. Do you have a family history of diabetes? YES NO

If yes, whom? _____

6. Do you have a family history of hypertension? YES NO

If yes, whom? _____

7. Do you have a family history of heart disease? YES NO

If yes, whom? _____

8. Do you have a family history of kidney disease? YES NO

If yes, whom? _____