6215 Humphreys Blvd Ste 200
Memphis, TN 38120

Bluff City OBGYN

Phone (901) 512-6086
Fax (833) 450-5323

PATIENT INFORMATION

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Race _____

Social Security Number _____ Married ___ Single ___ Widowed ___ Divorced ___

Occupation _____ Name of Employer _____

Employer Address _____ Work Number _____

Email Address _____

Pharmacy Name and Number _____

Emergency Contact Name and Number _____

INSURANCE POLICY HOLDER INFORMATION

Name _____ Address (if different) _____

Home Phone _____ Social Security Number _____ DOB _____

Name of Employer _____ Employer Phone _____

Employer Address _____

INSURANCE INFORMATION

Primary Insurance _____ Insured Name _____

Policy Number _____ Policy Group Number _____

Insurance Claims Address _____

Secondary Insurance _____ Insured Name _____

Policy Number _____ Policy Group Number _____

Insurance Claims Address _____

PLEASE READ AND SIGN BELOW

AUTHORIZATION: I hereby give my permission to Bluff City Obstetrics and Gynecology for medical treatment including but not limited to examinations, injections, blood test, diagnostic testing, or medical procedures deemed necessary and authorize Bluff City OBGYN to release any information concerning my treatment and irrevocably assign to them all insurance benefits for my treatment. I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance as reasonable and customary, whether covered by Medicare or other insurance. I understand the only TennCare plan Bluff City participates in is BlueCare. I understand that I am responsible for verifying my insurance coverage and pre-certifying my benefits with my insurance company. I also understand that I am responsible for reasonable collection costs and/or stationary fees incurred in the collection of this account. A photocopy of this statement is as valid as the original.

Patient Signature _____ Date _____

Bluff City Obstetrics and Gynecology

Confidential Patient Medical History

Name _____ Date of Birth _____ Date _____

ALLERGIES: Please list any known allergies to medicines, food, or medical products (latex, beta dine, or tape)

_____ _____ _____ _____

_____ _____ _____ _____

MEDICATIONS: Including over the counter medications, vitamins, herbs, and any other supplements.

Please list ALL Medications you are taking, Dosage, and how often you take it.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

MEDICAL HISTORY: Please check illnesses or conditions YOU have had.

Birth Control Method

Pregnancies # _____ Living Children # _____
Deliveries: Vaginal # _____ C-Section # ____ VBAC # _____
Miscarriages # _____ Abortions # _____

☐ Infertility

Age Menstruation began

Menses: ☐ Regular 21 - 35 days apart ☐ Irregular
☐ Duration of menses: _____ days
Menstrual flow: ☐ Mild ☐ Moderate ☐ Severe
☐ Dysmenorrhea (Painful Periods/Cramps)
☐ Uterine Disorder ☐ Fibroids

☐ Abnormal Pap Smear Date: _____
☐ Colpo ☐ Cryo ☐ LEEP ☐ CKC
Date(s): _____

☐ STD ☐ HIV ☐ Chlamydia ☐ Gonorrhea ☐ Herpes

☐ Breast Problems

☐ Cancer: ☐ Breast ☐ Ovarian ☐ Uterine ☐ Colon
☐ Other Cancer:

☐ Diabetes

☐ Thyroid Disorder: ☐ Goiter ☐ Underactive ☐ Overactive

☐ Migraines

☐ Eye Disease

Heart Disease: ☐ Atrial Fibrillation ☐ CHF ☐ CAD
☐ High Cholesterol
☐ High Blood Pressure (HTN)
Lung Disease: ☐ Asthma ☐ COPD ☐ Pneumonia
☐ Sleep Apnea
☐ Kidney Disease
Gastrointestinal Disorders: ☐ Cirrhosis ☐ Crohn's
☐ Diverticulitis GERD (Reflux) ☐ Hepatitis ☐ Irritable Bowel
☐ Ulcerative Colitis
Arthritis: ☐ Osteo ☐ Rheumatoid
☐ Osteopenia ☐ Osteoporosis
☐ Blood Clots in Legs (DVT) ☐ Phlebitis _____
☐ Blood Transfusion Date(s): _____
Mental Illness: ☐ Anxiety ☐ Bipolar ☐ Depression
☐ Seizure Disorder / Epilepsy ☐ Stroke
☐ Chicken Pox or ☐ Vaccine
☐ Autoimmune Disorder
☐ DES Exposure
Other History or Hospitalizations: _____

SURGICAL HISTORY: Please check operations or procedures with dates.

	Date		Date
☐ Ear Nose Throat Surgery _____		☐ Bladder or Kidney Surgery	
☐ Adenoid or Tonsillectomy		Female/Gynecology ☐ C-Section # _____ ☐ Tubal Ligation ☐ Uterine Ablation ☐ Pelvic Laparoscopy ☐ Hysterectomy ☐ D&C	
☐ Thyroid Surgery			
☐ Lung Surgery ☐ Heart Surgery ☐ Stents ☐ Bypass			
☐ Breast Surgery ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy ☐ Reduction ☐ Augmentation		☐ Hysterectomy: ☐ Abdominal ☐ Vaginal ☐ Supracervical ☐ Laparoscopic/Robotic	
☐ Abdominal Surgery ☐ Appendix		☐ Ovary removed ☐ Left ☐ Right ☐ Both	
☐ Gallbladder ☐ Hernia Repair ☐ Other _____ ☐ Knee Replacement ☐ Hip Replacement ☐ Orthopedic Surgery		Other Surgery: _____	

Name _____ Date of Birth _____ Date _____

SOCIAL HISTORY: Provide the following information about YOURSELF.

Do you exercise regularly? □ Yes □ No	Do you drink alcoholic beverages? □ Yes □ No How many? _____ More than 3 per day? □
Marital Status? □ Single □ Married □ Divorced	
Are you sexually active? □ Yes □ No	Do you use recreational drugs? □ Yes □ No If yes, which recreational drugs: _____
Work Status: □ Part-time □ Full-time □ Unemployed □ Retired □ Occupation: _____	How much? _____ How often? _____
Do you drink caffeinated beverages? □ Yes □ No If yes, how many per day? _____	Do you use herbal supplement or vitamins? □ Yes □ No
Tobacco or Cigarettes? □ Never Smoked □ Former Smoker: Date quit _____ □ Current Smoker: Amount per day _____ □ Other	Other social history: _____

FAMILY HISTORY: Check illnesses that have occurred in any of YOUR BLOOD RELATIVES.

	Relative		Relative
□ Heart Disease □ Early Deaths □ High Cholesterol □ High Blood Pressure		Cancers □ Breast □ Colon □ Cervical □ Ovarian □ Uterine □ Other Cancer	
□ Asthma		□ Stroke □ Seizure Disorder	
□ Diabetes □ Thyroid Disorder		Other Family History: □ Alcoholism □ Birth Defects □ Drug Abuse □ Genetic Disease □ Other:	
□ Gastrointestinal Disorders			
□ Osteoporosis □ Blood or Clotting Disorder			

IMMUNIZATIONS: Please check if you have received these adult immunizations and indicate when.

□ Tetanus date: _____ □ Tdap date: _____ □ Influenza (Flu) date: _____ □ Pneumonia date: _____
□ Gardasil Series of #3 date(s) _____

PRENATAL SCREENINGS: Date of last exam.

Complete Physical _____ Colonoscopy _____

Pap Smear _____ DEXA Scan (Bone Density) _____

Mammogram _____ Foot Exam (Diabetes) _____

Do you have any additional health information not covered? _____

_____

PHARMACY INFORMATION: Where would you like prescriptions sent?

Name _____ Phone _____ Address _____

Patient Signature _____ Date _____