Dr. Gwynn Patterson M.D., F.A.C.O.G.

Obstetrics and Gynecology, Aesthetics and Laser
4990 E Mediterranean Dr. Suite C
Sierra Vista, AZ 85635

Last Name:	First Name:		Middle Name:
Address:	City:	State:	Zip Code:
Home #:	Cell #:	E-mail:	
Social Security #:	DOB:		Marital Status:
Patient's Race:	Ethnicity:	Declined to specify	
Pharmacy:		Family Doctor:	
Emergency Contact:	Relationship:	Phone:	

Insurance Information

Please note you are responsible for knowing your insurance policies along with any copays and deductibles. Copays are due at time of service.

Primary Insurance:	ID#:	Group#:
Insured's name:	Insured's Date of Birth:	
Insured's Social Security #:	Insured's relationship to Patient:	
Secondary Insurance:	ID#:	Group#:
Insured's name:	Insured's Date of Birth:	
Insured's Social Security #:	Insured's relationship to Patient:	

Do you have a Living WILL? YES NO

No Show/ Cancellation Policy: You must give us 24hrs notice to cancel an appointment. If you no show for an appointment we will send you a letter and a bill for $50. Excessive No Shows/Cancellations and we will dismiss you from the practice.

Notice of Privacy Practice: A copy of the privacy practice is located in the office and offered to you based on the Health Insurance Portability and Accountability Act.

Please understand that this is an OB/GYN office and deliveries can upset the schedule. We do our best to give you sufficient notice if we need to re-schedule your appointment.

Children need to be in car seats or strollers.

Specimens are sent to an outside lab. Please make sure your insurance is contracted with the lab it is going to, you may get a bill from them.

Regarding all labs and pap smear results don't assume no news is good news. You can log onto the website of whatever lab you went to in order to get results. Pap smear results will be mailed to you, if for some reason you don't get it please call us.

Patient Signature:_____ **Date:**_____

☐ New Patient ☐ Established Patient DOB:_____ Date:_____

Race: ☐ Caucasian ☐ African Amer. ☐ Hispanic ☐ Asian ☐ _____ G____ P____ LC____ SAB____ VAB

Patient Name:_____

Age:_____

G = How many time you were pregnant **SAB** = How many spontaneous abortions
P = How many live births you had **VAB** = How many voluntary abortions
LC = Number of living children

CHIEF COMPLAINT (reason for the visit):

MEDICAL PROBLEMS: ☐ None

☐ Hyperlipidemia	☐ Osteoarthritis	☐ Hypercholesterolemia
☐ Hyperthyroid	☐ Hypothyroidism	☐ Hyperthyroidism
☐ Osteoporosis	☐ Osteopenia	☐ Allergies
☐ Heart disease	☐ Diabetes	☐ Acid reflux
☐ Breast Ca	☐ Colon Ca	☐ Ovarian Ca
☐ Migraine HA	☐ Fibromyalgia	☐ Depression
☐ Premature menopause		☐ Asthma

Other:

CURRENT MEDS: ☐ None

Med	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

ALLERGIES: ☐ None

Contraception: ☐ None ☐ BC pills ☐ Patch ☐ IUD
☐ Diaphragm ☐ husband w/vasectomy ☐ abstinence
☐ hysterectomy ☐ condoms ☐ Tubal ligation
☐ Other:_____

SURGICAL HISTORY

OB/GYN SURGERY:

Type:	Reason:	Date:
1.		
2.		
3.		

OTHER SURGERY:

Type:	Reason:	Date:

DO NOT FILL OUT: Office Use Only

LAST PAP: YEAR:_____ ☐ never Result: ☐ Normal ☐ ASCUS ☐ AGUS ☐ LGSIL ☐ HGSIL ☐ HPV ☐ Other

LAST COLONOSCOPY: YEAR:_____ ☐ never Result: ☐ Normal

LAST MAMMOGRAM: YEAR:_____ ☐ never Result: ☐ Normal

LAST CHOLESTEROL: YEAR:_____ ☐ never Result: ☐ Normal

LAST DEXA: YEAR:_____ ☐ never Result: ☐ Normal ☐ spine ☐ hip ☐ distal forearm
☐ mild osteopenia ☐ spine ☐ hip ☐ distal forearm
☐ mod osteopenia ☐ spine ☐ hip ☐ distal forearm
☐ osteoporosis ☐ spine ☐ hip ☐ distal forearm

FAMILY HISTORY

Name:_____ DOB:_____ Date:_____

Breast Cancer: ❑ yes ❑ no Maternal ONLY: Who: ❑ mother ❑ sister ❑ maternal aunt ❑ maternal grandmother

Uterine Cancer: ❑ yes ❑ no Maternal ONLY: Who: ❑ mother ❑ sister ❑ maternal aunt ❑ maternal grandmother

Ovarian Cancer: ❑ yes ❑ no Maternal ONLY: Who: ❑ mother ❑ sister ❑ maternal aunt ❑ maternal grandmother

Colon Cancer ❑ yes ❑ no ❑ mother ❑ father ❑ siblings

Diabetes ❑ yes ❑ no ❑ mother ❑ father ❑ siblings

Heart Disease ❑ mother ❑ father ❑ siblings

Osteoporosis ❑ yes ❑ no In mother ❑ yes ❑ no

Thrombosis (clots in legs) ❑ yes ❑ no ❑ mother ❑ father ❑ siblings

Pulmonary Embolism (clot in lungs) ❑ yes ❑ no ❑ mother ❑ father ❑ siblings

Positive family history of high cholesterol ❑ yes ❑ no ❑ mother ❑ father ❑ siblings

Mother: ❑ Living ❑ Deceased Cause of death:_____ Father: ❑ Living ❑ Deceased Cause of death:_____

Siblings: number living _____ number deceased _____

Causes of death:_____

SOCIAL HISTORY

Profession:_____

Tobacco use: ❑ yes ❑ no _____packs per day_____cigarettes per day

Alcohol use: ❑ yes ❑ no _____drinks per day_____drinks per week_____rarely

Recovering alcoholic: ❑ yes ❑ no

Illegal drugs: ❑ yes ❑ no

Domestic violence: ❑ yes ❑ no

Seat belt use: ❑ yes ❑ no

SEXUAL HISTORY

Are you a virgin? ❑ yes ❑ no Have you had oral sex? ❑ yes ❑ no

Are you sexually active? ❑ yes ❑ no If no, how long NOT active?_____

New sexual partners in the past 6 - 12 months? ❑ yes ❑ no

Heterosexual (man & woman) ❑ yes ❑ no Homosexual (same sex) ❑ yes ❑ no Bisexual (both men & women) ❑ yes ❑ no

Exercise: ❑ yes ❑ no

Walking: ❑ yes ❑ no How many miles: 1 2 3 4 5 x per week 1 2 3 4 5 6 7

Hiking: ❑ yes ❑ no How many miles: 1 2 3 4 5 x per week 1 2 3 4 5 6 7

Bike riding: ❑ yes ❑ no How many miles: 1 2 3 4 5 x per week 12 3 4 5 6 7

Weightlifting: ❑ yes ❑ no 5 10 15 20 lbs x per week 1 2 3 4 5 67

Gym: ❑ yes ❑ no x per week 1 2 3 4 5 6 7

NAME: _____ DOB: _____ DATE: _____

REVIEW OF SYSTEMS (ROS)

Problem Pertinent ROS = Positive & pertinent responses related to problem 99203 and 99213

Extended ROS = Positive & pertinent responses for 2-9 systems 99204 and 99214

Complete ROS = Positive & pertinent responses for at least 10 systems 99205 and 99215

IF YOU DO NOT HAVE ANY OF THE FOLLOWING PROBLEMS, PLEASE MARK THE NO PROBLEM BOX FOR ALL QUESTIONS.

1. Constitutional ❑ No problem ❑ Weight loss ❑ Weight gain ❑ Fever ❑ Fatigue / tiredness

2. Eyes ❑ No problem ❑ Vision change ❑ Glasses / contacts

3. ENT/Mouth ❑ No problem ❑ Lesions on the face ❑ Inflammation of sinuses ❑ Ringing in the ears
❑ Headache ❑ Other _____

4. Cardiovascular ❑ No problem ❑ Discomfort with breathing ❑ Chest pain ❑ Swelling

5. Respiratory ❑ No problem ❑ Wheezing ❑ Spitting up blood ❑ Shortness of breath ❑ Cough
❑ Other _____

6. Gastrointestinal ❑ No problem ❑ Diarrhea ❑ Bloody stool ❑ Nausea and vomiting ❑ Constipation
❑ Flatulence ❑ Pain with bowel movement ❑ Other _____

7. Genitourinary ❑ No problem ❑ Blood in urine ❑ Pain with urination ❑ Urgency ❑ Frequency
❑ Incomplete emptying ❑ Incontinent (unable to make it to restroom on time)
❑ Abnormal bleeding ❑ Pain with intercourse ❑ Other _____

8. Musculoskeletal ❑ No problem ❑ Muscle weakness
❑ Other _____

9. Skin/Breast ❑ No problems ❑ Painful breasts ❑ Discharge from the nipples ❑ Breast lumps ❑ Rash
❑ Skin lesions ❑ Other _____

10. Neurological ❑ No problem ❑ Fainting spells ❑ Seizures ❑ Numbness ❑ Trouble walking
❑ Other _____

11. Psychiatric ❑ No problem ❑ Depression ❑ Crying
❑ Other _____

12. Endocrine ❑ No problem ❑ Diabetes ❑ Overactive thyroid ❑ Underactive thyroid ❑ Hot flashes
❑ Other _____

13. Hemat/Lymph ❑ No problem ❑ Bruise easily ❑ Bleeding easily ❑ Swelling of the lymph nodes
❑ Other _____

NAME: **DATE:**
DATE OF BIRTH:

Incontinence Questionnaire

Please answer as accurately as possible.

1. Do you leak urine when you cough, sneeze, or laugh? **Yes / No**

2. Do you ever have such an uncomfortably strong need to urinate that if you reach the toilet you will leak? **Yes / No**

3. If "yes" to No. 2, do you ever leak before you reach the toilet? **Yes / No**

4. How many times during the day do you urinate?

5. How many times do you void during the night after going to bed?

6. Have you wet the bed in the past year? **Yes / No**

7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? **Yes / No**

8. Do you ever leak during or after sexual intercourse? **Yes / No**

9. Do you find it necessary to wear a pad because of your leaking? **Yes / No**

10. How often do you leak (times per day)?

11. Have you had bladder, urine, or kidney infections? **Yes / No**

12. Are you troubled by pain or discomfort when you urinate? **Yes / No**

13. Have you had blood in your urine? **Yes / No**

14. Do you find it hard to begin urinating? **Yes / No**

15. Do you have a slow urinary stream? **Yes / No**

16. Do you have to strain to pass your urine? **Yes / No**

17. After you urinate, do you have dribbling or a feeling that your bladder is still full? **Yes / No**

LASER MD SV

What Concerns You?

Check off the particular concerns you would be interested in learning about solutions to:

- ☐ Wrinkles
- ☐ Blotchy Skin
- ☐ Frown Lines
- ☐ Turkey Neck
- ☐ Crepe Skin
- ☐ Acne
- ☐ Facial Veins (we don't treat leg veins)
- ☐ Brown and red spots
- ☐ Droopy Eyes
- ☐ Excess Hair
- ☐ Sagging Face/Neck

Other concerns you have questions about:_____

_____

_____

Would You be interested in receiving e-mails from our office regarding our aesthetic services, promotions, etc?

YES EMAIL:_____ NO