Hawthorne
OBSTETRICS & GYNECOLOGY

Date _____

Patient's Full Name _____
Last Name First Name MI

Sex _____ Birthdate _____ Soc. Sec. Number _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Text Reminder ❑ Yes ❑ No

Email _____

Marital Status _____

Emergency Contact/Relationship _____ Phone _____

Patient's Employer _____ Occupation _____

Person Responsible for the Bill _____
(If Different from Patient) Last Name First Name MI

Primary Physician: _____ Pharmacy & Location: _____

Please Bring Your Insurance Card With You To Your Appointment
So That We Can Copy It For Our Records.

ADDITIONAL INFORMATION MAY BE PLACED ON THE BACK OF THIS FORM

Dear Patient,

The Staff at Hawthorne Obstetrics & Gynecology is trying to get a better sense of the overall diversity of our patient population so that we have a better understanding of our practice and patient needs. This confidential information is for quality monitoring purposes only and will never affect the quality of care you receive at Hawthorne Obstetrics & Gynecology. Thank You!

**Please Note: Primary Language is required. If you choose not to answer Race or Ethnicity, please check "Prefer not to answer."

Your Primary Language: _____

Race:

____ American Indian or Alaska Native ____ Asian ____ Black or African American
____ More than one race ____ Native Hawaiian ____ Other Pacific Islander
____ White ____ Prefer not to answer

Ethnicity:

____ Hispanic or Latino ____ Not Hispanic or Latino ____ Prefer not to answer

If you are a new patient to our practice, how did you hear about us? _____

Hawthorne
OBSTETRICS & GYNECOLOGY

Permission to Communicate with Family and Friends Form/Voicemail

So that we may serve you better, you have the option of providing us with a list of family and friends with whom we may discuss your health information. You are **not required** to provide a list or to sign this form.

By signing this form I give consent to Hawthorne Obstetrics & Gynecology to discuss health information with the people listed below who assist with my care. **If I do not want certain information discussed, I have listed it below.** I understand that sensitive information, like HIV and pregnancy test results, mental health or substance abuse will not be shared.

Name	Phone Number	Relationship

Do not discuss information about _____

☐	I give Hawthorne Obstetrics & Gynecology Permission to leave **Normal** Lab/Test results on my answering machine/voice mail.
☐	I **Do Not** give Hawthorne Obstetrics & Gynecology Permission to leave any Lab/Test results on my answering machine/voice mail.
☐	Allow release of information to the American Red Cross for communications with family members of the U.S. military, such as notifying service members of family illness or death, including verifying such illnesses for emergency leave requests. The following information may be provided: Physician Name, Diagnosis, Prognosis, Current Condition, Life Expectancy, and a recommendation for leave.

_____
Patient/Patient Representative Signature Date/Time Print Name

_____
Date of Birth Email

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

Hawthorne
OBSTETRICS & GYNECOLOGY

Patient Information Sheet

Name:_____ Date of Birth:_____ Date of scheduled visit: _____

***The following questionnaire allows our office to update your medical record. Please fill this form out and bring it with you to your appointment.**

Chief complaint or reason for your visit:

_____

- List of Current medications you are taking. Include any over the counter medications/supplements: **Include dosages.**

List any allergies to medications, foods or latex. Include reaction to each.

- List any surgeries that you have had, including dates:

Family History: List any major family health disease, (include cancers, diabetes, heart disease, thyroid problems, respiratory, Breast cancer, Ovarian cancer, Colon cancer, Uterine cancer, etc).

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Other Family: _____

– PLEASE COMPLETE OTHER SIDE –

Social History: Please circle answer or fill in response

- Do you drink alcohol? None, Occasional, Moderate, Heavy
- How much caffeine do you. consume in a day? None, Occasional, Moderate, Heavy
- Do you take any illicit drugs (marijuana, cocaine, etc.)? None, Occasional, Moderate, Heavy
  When did you last use drugs and what did you use? _____
- Do you smoke?: Never smoked, Occasional smoker, Everyday smoker, Former smoker
- If you quit smoking, when did you quit? _____

Obstetrical History:

As of today, how many times have you ever been pregnant? _____

Number of Miscarriages _____ Dates of Miscarriages _____, _____, _____

Number of abortions _____ Dates of abortions _____, _____

Number of Stillborns _____ Dates of deliveries _____, _____

Number of Live births _____ Dates of deliveries _____, _____,

_____, _____, _____, _____

Medical History:

When was the first day of your last menstrual period? _____

List any medical problems that you have (example: High blood pressure, depression, diabetes, thyroid issues, heart issues, etc.) _____

_____

*Who is your Primary Care Physician/phone number? _____

*Have you ever had the Gardasil HPV (Human Papilloma Virus) vaccine? Yes or NO

*If yes, have you had all 3 injections? Yes or NO If no, how many did you get and when was the date of your last injection? _____

*When was the date of your last:

Pap Smear _____, was it normal Yes or NO Explain_____

Mammogram _____, was it normal Yes or NO Explain_____

Colonoscopy _____, was it normal Yes or NO Explain_____

Bone Density _____, was it normal Yes or NO Explain_____

Pharmacy Information:

Name of your pharmacy _____ Phone: _____

Address, City, State: _____

4605 Country Club Road, Winston-Salem, NC 27104
(336) 768-3632 FAX (336) 768-4473

ACKNOWLEDGEMENT — NOTICE OF PRIVACY PRACTICES

I have been given an opportunity to read Hawthorne Obstetrics & Gynecology *Notice of Privacy Practices.* I have been given a copy if I requested one.

Patient (print name) _____

Patient (signature) _____

Date _____