ELITE
WOMEN'S CARE

PATIENT INFORMATION

(Please Print Clearly)

Date: ……../……../……

Name: (First, Middle Initial, Last) _____

Address: _____
Street, Apt # *City* *State* *Zip*

Home Phone Number: _____ **Cell Number (If Applicable):**_____

Emergency Number: _____ **Driver's License #:**_____

SS#:_____ **DOB:** _____ **Age:** _____ **Race:** _____

Marital Status: _____ **Religion:** _____

Name of your Primary Care Physician_____ **Phone Number:** _____

Patient's Employment

Employed By: _____ **Occupation:** _____

Address: _____ **Business Phone:** _____ **ext.** _____
Street City State Zip

Spouse's Information

Spouse's Name: _____ **SS#:**_____ **DOB:** _____

Spouse's Employer: _____ **Business Phone:** _____

Employer's Address: _____
Street *City* *State* *Zip*

Who Referred You To This Office:_____
(This reference is for office use only)

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Medical Insurance Information

Please give your card to receptionist for photocopy and/or insurance form if applicable

INSURANCE INFORMATION

Insurance Company Name or Hub (IPA):_____ **Phone:** _____

Group Number: _____ **Policy Number:** _____ **Effective date:** _____

Policy Holder's Name: _____ **DOB:** _____

***Secondary Insurance Name*:** _____ **Phone:** _____

Group Number: _____ **Policy Number:** _____ **Effective date:** _____

Responsible Party

Please complete the following if someone other than you the patient or your spouse is responsible for this bill, example: Child, Dependent –

Guarantor's Name: _____ **Relationship to the Patient:** _____

Address of Guarantor: _____ **DOB:** _____
Street *City* *State* *Zip*

Home Phone Number: _____ **Business Phone Number:** _____

Employed By: _____

Signature of Guarantor of Payment: _____ **Date:** _____

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Record of Personal History

Date: ……../……../……

NAME: _____ **AGE:**_____ **DOB:** _____

Are you here for a routine check up? ◯ **Yes** ◯ **No**

If you have any medical problems at this time please state: _____

Past History

Have you ever had any operations such as tonsillectomy, hysterectomy, etc.?

List WHEN, WHERE, & WHAT Type of Surgery:

_____

Medical History

Mark an "X" in the Appropriate Response

	YES	NO		YES	NO
Asthma	☐	☐	**Heart Attack**	☐	☐
Cancer	☐	☐	**Hepatitis**	☐	☐
DES Child	☐	☐	**High Blood Pressure**	☐	☐
Diabetes	☐	☐	**Other:** _____		

Explanation of above: _____

Skin

(Circle Y=Yes N=No)

Prolonged bleeding from cuts? Y N
Blood clots in legs? Y N

Gastrointestinal

Chronic Constipation or Diarrhea? Y N
Recent Change in Bowel Habits? Y N
Bloody or Tarry stools? Y N
Gallbladder disease, ulcer, jaundice, colitis? Y N

Eyes

Wear glasses or contact lenses? Y N

Urinary Tract

Ever had Kidney or Bladder Infections? Y N
NOW have pain, urgency or burning with Urination? Y N
Ever passed blood in your urine? Y N

Ears

Difficulty in Hearing? Y N
Ringing in the Ears? Y N
Frequent Dizzy Spells? Y N

Neuromuscular

Ever had a convulsion? Y N
Ever had swollen, red or stiff joints? Y N
Have paralysis or deformity? Y N

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Nose, Mouth, Throat

Frequent Nose Bleeds?	Y	N
Wear Dentures?	Y	N
Frequent Sore Throats?	Y	N
Hay fever or Allergies?	Y	N

Endocrine

Any Thyroid problems?	Y	N
Ever been told you are diabetic?	Y	N
Has your weight varied over 10 pounds in the last year?	Y	N

Chest

Ever had high blood pressure?	Y	N
Heart trouble, murmur, or pain?	Y	N
Sever shortness of breath?	Y	N
Chronic cough?	Y	N
Ever cough up blood?	Y	N
Ankle swelling?	Y	N
Heart often skips a beat or race?	Y	N

Family History

List Disease and how it relates to you – Name: _____

Cancer, Diabetes, Heart Disease, Stroke, Other Major History:

_____

_____

_____

Social History

Marital Status: _____ How Many Years? _____

If Divorced, how long? _____

Is your marriage satisfactory? _____ Do you Drink? _____ How Much? _____

Are you usually depressed lately? _____ Do you smoke? _____ How Much? _____

Are you presently taking recreational drugs, marijuana, cocaine, etc? _____

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Gynecological & Obstetrical History

Date of Last Pap?_____

Date of last Menstrual Period?_____ **Was it Normal?**_____ **Days Flow?**_____

Number of Days Between Periods?_____ **At What age did you begin your Period?**_____

How many pads/tampons per day at the beginning of your Period?_____**& at the End?**_____

What type of Birth Control are you now using? (*Please Circle*) **None IUD Diaphragm Tubal ligation**

Vasectomy Pill (which one?)_____ **or Other Method:**_____

(Circle Y=Yes N=No for the following questions)

Are your periods irregular?	**Y**	**N**	**Have you ever had a Pelvic Infection?**	**Y**	**N**
Pain with or prior to Periods?	**Y**	**N**	**Have you passed the "Change of Life"?**	**Y**	**N**
Clots with Periods?	**Y**	**N**	**If the above is Yes:**		
Any bleeding between Periods?	**Y**	**N**	**Have you had any bleeding?**	**Y**	**N**
Any bleeding during or after sex?	**Y**	**N**	**Any "Hot Flashes"**	**Y**	**N**
Any pain with sex?	**Y**	**N**	**Do you take hormones?**	**Y**	**N**
Medication for pain with periods?	**Y**	**N**	**Have you noticed any lumps or discharge**		
Any Abnormal vaginal discharge?	**Y**	**N**	**From breasts or nipples?**	**Y**	**N**
Ever had a Venereal Disease?	**Y**	**N**	**Do you lose urine when you cough or**		
Ever had German Measles?	**Y**	**N**	**Sneeze?**	**Y**	**N**

Pregnancies

How many Pregnancies? _____ **How many Living Children?**_____

Age at First Pregnancy? _____

How many Miscarriages or Abortions?_____ **Any Premature Babies?**_____

List in order all your Pregnancies or use separate sheet if necessary:

Date	**Sex**	**Weight**	**Any Complications**	**List- Cesarean Sections, Breech, Etc.**

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Drugs Recently Taken

Pharmacy Name, address & phone – Attach additional sheet –

_____

_____

Allergies & Sensitivities

Allergies & Sensitivities:

_____

_____

MAIL FORM TO:

Elite Women's Care, Inc. Main Office:

1555 North Barrington Road, #410, Doctor's Office Building One, Hoffman Estates, IL 60169 OR FAX TO: 847.781.1895 At least 72 hrs prior to your scheduled appointment.