Today's date:	Physician Name:

PATIENT INFORMATION

Patient's Last name: First: Middle:	❑ Mr. ☐ Mrs.	Sex: ☐ M☐ F	Marital status (circle one) Single / Mar / Div / Sep / Wid

Mailing address:	City:	State:	ZIP Code:

D.O.B: / /	Social Security No.:	Home phone no.: ( )	Cell Phone No.: ( )

Email Address:	Local Pharmacy:	Pharmacy Phone No.:

SPOUSE INFORMATION

Spouse's Last name: First: Middle:	❑ Mr. ❑ Mrs.	Social Security No.:

D.O.B: / /	Phone No.: ( )	Email Address:

REFERRAL INFORMATION

Referred by(Clinic/Doctor):

Referring Clinic/Doctor's Address:	Referring Clinic/Doctor Phone No.:

☐ Family ☐ Friend ☐ Other________________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PRIMARY Insurance:	Group Name(Employer):	Effective Date:	Policy No.:	Group No.:

Subscriber's Name:	Subscriber's D.O.B: / /	Subscriber's Address (***if different***):	Phone No.: ( )

Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other

SECONDARY Insurance (***if applicable***):	Group Name(Employer):	Effective Date:	Policy No.:	Group No.:

Subscriber's Name:	Subscriber's D.O.B: / /	Subscriber's Address (***if different***):	Phone No.: ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize UNC Fertility or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

NEW GYNECOLOGY PATIENT PROFILE

Last name ______________________ First Name ________________________

Date of birth ____________________

Preferred Contact Number_________________________Is this a confidential line?
☐ Yes ☐ No

Referring Physician______________________________

Occupation_____________________________________

Pharmacy Preference (Name, address) ______________________________________
____

What is the primary reason for your visit today?

____
____
____

MEDICAL HISTORY

Height____________Weight___________

Have you ever been pregnant?
☐ Yes ☐ No

If yes, ______Number of spontaneous miscarriages

______Number of elective abortions

______Ectopic pregnancies

______Preterm births less than 37 weeks

______Term births greater than 37 weeks

Are your menstrual cycles regular? ☐ Yes ☐ No

How many days from day 1 of your period to day 1 of the next?_________

How many days do you bleed?_____

Do you have pain with your menstrual cycles? ☐ Yes ☐ No

If yes, how severe is your pain?

Mild				Moderate					Severe
1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you take medication for menstrual pain? ☐ Yes ☐ No

If yes, what do you take and how much? ______________________________

When was your last pap smear? ______________________________________

HISTORY OF GYNECOLOGIC PROBLEMS

☐ Yes ☐ No Infections in the tube or ovaries

☐ Yes ☐ No Abnormal pap smears

☐ Yes ☐ No Uterine fibroids

☐ Yes ☐ No Gynecologic surgery

Have you ever been diagnosed with any of the following? Check all that apply:

☐ Yes ☐ No Anxiety or Depression

☐ Yes ☐ No Heart problems

☐ Yes ☐ No Lung problems

☐ Yes ☐ No High blood pressure

☐ Yes ☐ No Kidney problems

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Asthma

☐ Yes ☐ No Thyroid problems

☐ Yes ☐ No Other____

SURGERIES *(please list)*

Procedure #1____Date____________________

Procedure #2____Date____________________

Procedure #3____Date____________________

ALLERGIES *(please list)*

____

____

____

CURRENT MEDICATIONS Please *include non-prescription medications and dietary or herbal supplements. Please include doses.*

____

____

____

Do you use any of the following?

☐ Yes ☐ No Tobacco

☐ Yes ☐ No Alcohol

☐ Yes ☐ No Recreational drugs

Marital Status:

☐ Single ☐ Separated ☐ Widowed

☐ Married ☐ Divorced

Informed Consent: Email communication

On occasion, we engage in email communication with our patients. Please review the information below about the limitations and risk of email communication. Please select one of the options below.

While UNC Fertility safeguards your medical records and personal data while it is in our control, we cannot assure, and are not responsible, for the safety of your personal medical information once it leaves our server. UNC Fertility is not responsible for misdirected or incorrectly routed emails due to incorrect or outdated information, email addresses shared with others, or 'send failure' because the email inbox is full.

I have read and understand the above paragraph. I would like to receive emails from UNC Fertility. Email address: ____________________________________

____________________________	______________________________	_________
Patient Signature	Patient Name	Date

I have read and understand the above paragraph. I would NOT like to receive email communication from UNC Fertility.

____________________________	______________________________	_________
Patient Signature	Patient Name	Date