

## **Welcome to Union OB/GYN**

Please complete and sign the enclosed papers and bring them with you to your scheduled appointment on: \_\_\_\_\_

Please be sure to fill out the Patient Intake form in its entirety, including: name, date of birth and Social Security number on each page as well as allergies to medications or latex

**On the day of your appointment, please be sure to bring:**

Insurance card

Photo I.D.

Co-payment due

A list of your current medications

In order to minimize delays for you and other patients, failure to have paperwork completed will result in your appointment being rescheduled.

**If you do not show for your first visit, you will not be rescheduled.**

Please call us with any questions or concerns. Thank you for giving us this opportunity to serve you.

Union OB/GYN  
Sarah A. Barber, D.O. and staff  
204 S. Bellevue Ave  
Dover, Ohio 44622  
(330)602-3098  
You may visit our website at:  
[www.unionobgyn.com](http://www.unionobgyn.com)

FOR OFFICE USE ONLY  
 NEW PATIENT  
 ESTABLISHED PATIENT  
 CONSULTATION  
 REPORT SENT.     /   /

**UNION OB/GYN**  
**SARAH BARBER, D.O.**

**PATIENT INTAKE HISTORY**

PATIENT NAME:		BIRTH DATE:    /    /	SS #:	DATE:    /    /
ADDRESS				
CITY:		STATE/ZIP:		
HOME TELEPHONE: (    )		WORK TELEPHONE: (    )		
EMPLOYER:		INSURANCE:	POLICY NO.:	
NAME YOU WOULD LIKE US TO USE:		NAME OF SPOUSE/PARTNER:		
NAME OF INSURED:		BIRTH DATE:    /    /	SS #:	
EMERGENCY CONTACT:		RELATIONSHIP:		
		HOME TELEPHONE: (    )	WORK TELEPHONE: (    )	
PHARMACY LOCAL:		MAIL ORDER:		
WHY HAVE YOU COME TO THE OFFICE TODAY?			REFERRED BY:	
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A <input type="checkbox"/> PRIMARY CARE VISIT OR <input type="checkbox"/> GYNECOLOGY ONLY				
IS THIS A NEW PROBLEM?				
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED.				

**GYNECOLOGIC HISTORY**

	PHYSICIAN'S NOTES
AGE PERIODS BEGAN: _____ LAST MENSTRUAL PERIOD: _____	
DAYS BETWEEN PERIODS _____ LENGTH OF FLOW _____	
HAVE YOU EVER HAD SEX? _____ ARE YOU CURRENTLY SEXUALLY ACTIVE? _____	
NUMBER OF SEXUAL PARTNERS (LIFETIME): _____	
SEXUAL PARTNERS ARE <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST? _____ WHAT WAS THE RESULT? _____	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (GONORRHEA, CHLAMYDIA, ETC)?	
WHEN WAS YOUR LAST MAMMOGRAM? _____ HAS IT EVER BEEN ABNORMAL? _____	
WHEN WAS YOUR LAST DEXA OR BONE DENSITY TEST?	
WHEN WAS YOUR LAST COLONOSCOPY?	

## PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	BIRTH DATE:    /    /	SS #:	DATE:    /    /
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### OBSTETRIC HISTORY

		NUMBER			NUMBER			NUMBER
PREGNANCIES			ABORTIONS			MISCARRIAGES		
PREMATURE BIRTHS (<37 WEEKS)			LIVE BIRTHS			LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)		PHYSICIAN'S NOTES	
1.								
2.								
3.								
4.								
ANY PREGNANCY COMPLICATIONS?								
<input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE <input type="checkbox"/> PREECLAMPSIA/TOXEMIA <input type="checkbox"/> OTHER								
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW TREATED								

### CURRENT MEDICATIONS (Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

### FAMILY HISTORY

MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE:		AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE:		AGE:
SIBLINGS: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET		PHYSICIAN'S NOTES	
DIABETES	<input type="checkbox"/>				
STROKE	<input type="checkbox"/>				
HEART DISEASE	<input type="checkbox"/>				
BLOOD CLOTS IN LUNGS OR LEGS	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>				
HIGH CHOLESTEROL	<input type="checkbox"/>				
OSTEOPOROSIS (WEAK BONES)	<input type="checkbox"/>				
HEPATITIS	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>				
TUBERCULOSIS	<input type="checkbox"/>				
BIRTH DEFECTS	<input type="checkbox"/>				
ALCOHOL OR DRUG PROBLEMS	<input type="checkbox"/>				
BREAST CANCER	<input type="checkbox"/>				
COLON CANCER	<input type="checkbox"/>				
OVARIAN CANCER	<input type="checkbox"/>				
UTERINE CANCER	<input type="checkbox"/>				
MENTAL ILLNESS/DEPRESSION	<input type="checkbox"/>				
ALZHEIMER'S DISEASE	<input type="checkbox"/>				
OTHER	<input type="checkbox"/>				



PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /
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### REVIEW OF SYSTEMS (ROS)

<b>1. CONSTITUTIONAL</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> WEIGHT GAIN	<input type="checkbox"/> CHANGE IN WEIGHT	TALLEST HEIGHT _____
	<input type="checkbox"/> FEVER	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> OTHER		
<b>2. EYES</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> VISION CHANGE	<input type="checkbox"/> GLASSES/CONTACTS		
	<input type="checkbox"/> OTHER				
<b>3. EAR, NOSE, AND THROAT</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> ULCERS	<input type="checkbox"/> SINUSES	<input type="checkbox"/> MOUTH SORES	
	<input type="checkbox"/> HEADACHE	<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> OTHER	<input type="checkbox"/> DENTAL PROBLEMS	
<b>4. CARDIOVASCULAR</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> DIFFICULTY BREATHING ON EXERTION		
	<input type="checkbox"/> SWELLING IN LEGS	<input type="checkbox"/> RAPID HEART BEAT	<input type="checkbox"/> OTHER		
<b>5. RESPIRATORY</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> COUGHING UP BLOOD		
	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> COUGH	<input type="checkbox"/> OTHER		
<b>6. GASTROINTESTINAL</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> BLOODY STOOL	<input type="checkbox"/> NAUSEA/VOMITING/INDIGESTION	
	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FLATULENCE	<input type="checkbox"/> PAIN	<input type="checkbox"/> INVOLUNTARY LOSS OF GAC/STOOL	<input type="checkbox"/> OTHER
<b>7. GENITOURINARY</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> BLOOD IN URINE	<input type="checkbox"/> PAINFUL URINATION	<input type="checkbox"/> URGENCY	
	<input type="checkbox"/> FREQUENCY	<input type="checkbox"/> INCOMPLETE EMPTYING		<input type="checkbox"/> INCONTINENCE	
	<input type="checkbox"/> PAINFUL INTERCOURSE	<input type="checkbox"/> ABNORMAL OR PAINFUL PERIODS		<input type="checkbox"/> PMS	
	<input type="checkbox"/> ABNORMAL VAGINAL BLEEDING	<input type="checkbox"/> ABNORMAL VAGINAL DISCHARGE		<input type="checkbox"/> OTHER	
<b>8. MUSCULOSKELETAL</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> MUSCLE WEAKNESS			
	<input type="checkbox"/> MUSCLE OR JOINT PAIN	<input type="checkbox"/> OTHER			
<b>9a. SKIN</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> RASH	<input type="checkbox"/> ULCERS	<input type="checkbox"/> SKIN CHANGES	
	<input type="checkbox"/> DRY SKIN	<input type="checkbox"/> MOLES	<input type="checkbox"/> OTHER		
<b>9b. BREAST</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> PAIN IN BREAST			
	<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> LUMPS	<input type="checkbox"/> OTHER		
<b>10. NEUROLOGIC</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> PASSING OUT	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> NUMBNESS	
	<input type="checkbox"/> TROUBLE WALKING	<input type="checkbox"/> SEVERE MEMORY PROBLEMS	<input type="checkbox"/> OTHER		
<b>11. PSYCHIATRIC</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> CRYING		
	<input type="checkbox"/> SEVERE ANXIETY	<input type="checkbox"/> OTHER			
<b>12. ENDOCRINE</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HYPOTHYROID	<input type="checkbox"/> HYPERTHYROID	
	<input type="checkbox"/> HOT FLASHES	<input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HEAT/COLD INTOLERANCE	<input type="checkbox"/> OTHER	
<b>13. HEMATOLOGIC/LYMPHATIC</b>	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> BRUISES			
	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> ENLARGED LYMPH NODES/GLANDS	<input type="checkbox"/> OTHER		
<b>14. ALLERGIC/IMMUNOLOGIC</b>	MEDICATIONS (PLEASE LIST) <input type="checkbox"/> LATEX <input type="checkbox"/> OTHER				

FORM COMPLETED By:  PATIENT  OFFICE NURSE  PHYSICIAN  OTHER:

SIGNATURE OF PATIENT:

DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /

PHYSICIAN SIGNATURE:

**PHYSICIAN'S NOTES:**


**ANNUAL REVIEW OF HISTORY**

DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
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