RSVP
OBGYN and Midwifery
112 Suite 300
120 Suite 208
La Casa Via, Walnut Creek, CA 94598

Patient Intake Form

PATIENT INFORMATION

Last name:	First name:	
Preferred name:	Pronouns:	
Birthdate:	SSN:	Phone #:
Email Address:		Home #:
Address:		
Marital status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed		Religion:
Employment status: ☐ Full time ☐ Part time ☐ Not employed ☐ Retired ☐ Student		Occupation:
Primary Care Provider:	Referring Physician:	
Preferred Spoken Language:	Preferred Written Language:	

EMERGENCY CONTACT

Name:	Relationship:
Phone number:	

☐ Check if minor (less than 18)
☐ Check if parent/guardian SAME as emergency contact listed above
☐ Check if parent/guardian DIFFERENT from emergency contact listed above

- Parent/Guardian name/relationship: _____

PHARMACY

Pharmacy:
Address:

HEALTH INSURANCE

☐ Yes ☐ No

Insurance Provider:	Policy #:
Subscriber:	Group #:
Subscriber DOB:	Relationship to patient:

Secondary Insurance

☐ Yes ☐ No

Insurance Provider:	Policy #:
Subscriber:	Group #:
Subscriber DOB:	Relationship to patient:

SIGNATURE: _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to RSVP of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. If the patient is a minor (under 18 years old), the responsible parent or guardian must sign

SIGNATURE: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

Messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information (PIH), may be left for me on voicemail at the telephone numbers below, in addition to any numbers provided to you by me.

☐ Yes ☐ No

- Additional #: _____
- Additional name & #: _____

SIGNATURE: _____

Medical History

CURRENT MEDICATIONS & ALLERGIES

Current medications: name, dosage, how often you take them	Allergies & Reaction
	Are you LATEX ☐ allergic ☐ sensitive ☐ n/a

GYNECOLOGIC/OBSTETRIC HISTORY

Menstruation

- First Ever Menstrual Period: _____
- Last Menstrual Period: _____
- Age when period stopped (if in menopause): _____
- How often does your period come? _____
- How long do your periods last? _____
- Any changes to your period recently? _____
- Do you have painful periods? ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Do you have PMS? ☐ None ☐ Mild ☐ Moderate ☐ Severe
- What are your symptoms? _____

_____

- How do you treat your symptoms: _____

_____

Pregnancies

- Have you ever been pregnant? ☐ Yes ☐ No
- # of times you have been pregnant: _____
- # of Full Term Births: _____
- # of Premature Births: _____
- # of Miscarriages: _____
- # of Abortions: _____
- # of Stillbirths: _____
- # of Living Children: _____

Medical History

Sexual Activity

- Are you currently sexually active? ☐ Yes ☐ No
- Number of sexual partners in the last year: _____
- Do you have sex with: ☐ people with penises ☐ people with vaginas ☐ both
- Do you have pain with intercourse: _____

Birth control and Hormone Therapy

- Do you currently use any form of birth control - for either pregnancy prevention or period management?

☐ None	☐ Implant (Nexplanon)	☐ Condoms
☐ Birth control pills	☐ Birth control patch	☐ Withdrawal
☐ IUD hormonal	☐ Vaginal Ring	☐ Natural Family Planning
☐ IUD non-hormonal	☐ Birth control shot	☐ Permanent (Vasectomy/Tubal)

- Do you use menopausal hormone therapy? ☐ Yes ☐ No
  - If so, what do you use: _____
- If you are interested in starting hormone therapy (for menopause or birth control), do you have a personal history of any of the following?

Cardiovascular & Blood Disorders:

- ☐ Migraines with aura
- ☐ History of stroke
- ☐ History of blood clots
- ☐ High blood pressure

History of hormone dependent cancer:

- ☐ Breast
- ☐ Ovarian
- ☐ Uterine

Other:

- ☐ Liver Disease
- ☐ Undiagnosed vaginal bleeding

Additional History

- Date of last pelvic/PAP exam: _____
- Date of last mammogram: _____
- Surgical History with Month/Year of procedure:

_____ _____
_____ _____
_____ _____
_____ _____

Medical History

SOCIAL HISTORY

- Do you smoke? ☐ Yes ☐ No ☐ Former
- Do you drink? ☐ Yes ☐ No
  - if so, # of drinks per day/week: _____
  - Do you think you drink too much? ☐ Yes ☐ No
- Do you currently or have you ever had an eating disorder: ☐ Yes ☐ No
- Have you experienced any of the following?

☐ None
☐ Physical abuse or violence
☐ Sexual abuse or assault
☐ Emotional or psychological abuse
☐ I prefer not to answer

PAST MEDICAL HISTORY

☐ Abnormal PAP Smear
☐ HPV
☐ Genital Warts
☐ Breast Lumps/Nipple Discharge
☐ Endometriosis
☐ Pelvic Inflammatory Disease
☐ Herpes
☐ Gonorrhea
☐ Chlamydia
☐ Pathologic Ovarian Cysts
☐ Uterine Fibroids
☐ Chronic Urinary Tract Infections
☐ Depression
☐ Anxiety
☐ Anorexia/Bulimia
☐ Diabetes
☐ DVT or Phlebitis
☐ Heart Disease
☐ High Blood Pressure
☐ Liver or Gallbladder Disease
☐ Migraines or other type of Headaches
☐ Stroke
☐ Thyroid Disorder
☐ _____

FAMILY HISTORY

Please include specifically which family member (i.e. mother, father, brother, sister, grandparent, aunt, and maternal/paternal). For cancer, please indicate age of diagnosis.

☐ Breast cancer: _____
☐ Ovarian cancer: _____
☐ Cervical/uterine cancer: _____
☐ Colon Cancer: _____
☐ Osteoporosis: _____
☐ Stroke: _____
☐ Inheritable genetic disorder: _____

SIGNATURE: _____