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
420 S. James St. Suite C,
Dover, Ohio 44622
(330)602-3098
You may visit our website at:
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 ☐ PRIMARY CARE VISIT OR ☐ 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 ☐ MEN ☐ WOMEN ☐ 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: / /

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?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

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

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE: | FATHER: ☐ LIVING ☐ 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	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
ALCOHOL OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

PATIENT INTAKE HISTORY *(Continued)*

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

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS DAILY INTAKE:	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL?)	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE UNITED STATES: LOCATION(S):

PERSONAL PAST HISTORY OF ILLNESSES/DISEASES

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

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

REVIEW OF SYSTEMS (ROS)

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