

GLEN S. LOVELACE, MD PA.
GYNECOLOGY

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Tel: 208-345-3136 Fax: 208-345-0984 www.idahostork.com

Patient's Legal Name:		Nickname:	
DOB:	Age:	SSN:	
Mailing Address:		Apt/Suite:	
City:	State/Zip:	Marital Status: S M W D Other	
Daytime Phone:	Cell Phone:	Work Phone:	
Email Address:		Appointment Reminder: Voice Text	
Employer		Occupation:	
Spouse/Partner Name:	DOB:	Cell phone:	
Employer:	Occupation:	Work phone:	

NOTE: If your information has not changed since your last appt, you do not need to fill this section out.

Primary Insurance:	Policy Holder: Self Spouse Parent Other
Group #	Policy/ID #:
*** If patient is a minor OR under a parent's insurance , the following information is REQUIRED ***	
Policy Holder's Name:	Employer: DOB:
Policy Holder's Address:	
Secondary Insurance:	Policy Holder: Self Spouse Parent Other
Group #:	Policy/ID #:
*** If patient is a minor OR under a parent's insurance , the following information is REQUIRED ***	
Policy Holder's Name:	Employer: DOB:
Policy Holder's Address	
*** If you do not provide the policy holder's insurance information, you will be considered self-pay ***	

NOTE: If your information has not changed since your last appt, you do not need to fill this section out.

Emergency Contact Name:	Relationship to Patient:
Home Phone:	Cell Phone: Work Phone:
Referred to our clinic by:	Primary Care Physician:
Preferred Hospital:	Preferred Pharmacy:

Your insurance company expects us to collect your co-payment at the time of service. All accounts are due and payable at time of visit unless other arrangements are made prior to your appointment. I hereby authorize the Dr. Lovelace to release any information acquired in the course of my treatment to my insurance company if requested. Additionally, I authorize payment to be made to Glen S Lovelace MD PA, for any and all medical or surgical services rendered. I also give my consent to view my prescription history. I understand I am financially responsible for charges not paid by my insurance company. **I also understand I will receive charges outside of this office for lab work, pathology, x-rays, and other medical procedures that may or may not be covered by my insurance company.**

Signature: _____

Date: _____

PATIENT NAME:

DOB:

DATE:

ACCOUNT:

Family History	Living		Deceased		Has any relative ever had:	Who?
	Age	Health	Age	Cause		
Father					Cancer	YES NO
Mother					Diabetes	YES NO
Brother or sister	1				Epilepsy	YES NO
	2				Heart disease	YES NO
	3				High blood pressure	YES NO
	4				Hysterectomy	YES NO
Husband					Kidney disease	YES NO
Son or daughter	1				Mental illness	YES NO
	2				Stroke	YES NO
	3				Suicide	YES NO
	4				Thyroid disease	YES NO

Menstrual History

Age at onset _____

Regular YES NO

Cycle days (from start to start) _____ days

Usual duration _____

Flow: Light Moderate Heavy

Aches or cramps YES NO

Date of last period _____

List Pregnancies (include miscarriages)

Year	Weight of baby	Sex	Hours of labor	Anesthesia	Complications?

Personal History

Allergies: YES NO If yes, please list: _____

Medications & supplements currently taking: _____

Surgery - what, when: _____

Method of contraception: _____

Date of last pap smear: _____

Last mammogram: _____

Primary Care Physician: _____

Name(s) of specialist(s) you see: _____

Do you now have or have you ever had...

Abnormal Pap Smear	YES	NO
Year		Treatment
Anemia	YES	NO
Asthma	YES	NO
Autoimmune disease	YES	NO
Breast disease	YES	NO
Cancer	YES	NO
Chest pain or shortness of breath	YES	NO
Chronic or frequent cough	YES	NO
Depression or anxiety	YES	NO
Diabetes	YES	NO
Epilepsy	YES	NO
Fractures or injuries	YES	NO
Frequent headaches	YES	NO
Frequent UTIs	YES	NO
Gallbladder disease	YES	NO
Head injury or fainting spells	YES	NO
Heart disease or murmur	YES	NO
High blood pressure	YES	NO
Indigestion stomach trouble or ulcer	YES	NO
Kidney or bladder disease	YES	NO

Do you now have or have you ever had...

Liver disease or Hepatitis	YES	NO
Loss of urine with cough or sneeze	YES	NO
Night sweats, hot flashes	YES	NO
Pneumonia	YES	NO
Rectal bleeding, constipation or diarrhea	YES	NO
Sexually transmitted disease (STD)	YES	NO
Any sexual problems?	YES	NO
If yes, do you wish to discuss them?		
Skin disease	YES	NO
Swelling of hands, feet or ankles	YES	NO
Thrombophlebitis or blood clots	YES	NO
Thyroid dysfunction	YES	NO
Current medication:		
Transfusions	YES	NO
Trauma or PTSD	YES	NO
Varicose veins	YES	NO
Other	YES	NO
Do you drink Alcoholic beverages?	YES	NO
Do you use any other tobacco products or vape?	YES	NO
If you smoke cigarettes, how many packs per day?		