Wynn Gynecology & Obstetrics
29201 Telegraph Rd Suite 605
Southfield, MI 48034
Tel: (248) 784-0600 Fax: (248) 784-0610

Patient Demographics Form

Patient Name:		
Mailing Address:		
Home Phone:	Cell Phone:	Work Phone:
Date of Birth:	Marital Status:	
E Mail Address:	Language:	
Social Security Number:	Race: Ethnicity: Hispanic Not Hispanic	
Emergency Contact Name:	Phone Number:	
	Relationship:	
Primary Insurance:	Policy Holder Name:	
Policy ID:	Date of Birth:	
Secondary Insurance:	Policy Holder Name:	
Policy ID:	Date of Birth:	

Primary Care Provider:	Referring Provider:
Ok to Leave Message at Home:	Ok to Leave Message at Work:
Pharmacy Name:	Pharmacy Location:

I authorize the release of any medical or other information necessary to process this claim. I authorize that any benefits due me be paid directly to my physician who accepts assignment. I am financially responsible for any uncovered charges. It is our policy to request payment at the time of services for any charges not covered by insurance.

Please list below all parties we are authorized to speak with regarding your account and medical information: (EX: Name of Spouse, Name of Mother)

_____ _____ _____ _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I agree with the statement above and I acknowledge that I have received the attached Privacy Notice.

_____ _____
Patient's Signature (Parent's signature if under 18) Date

If Personal Representative's signature appears above please describe Personal Representative's relationship to patient

_____
Relationship to Patient

Wynn Gynecology & Obstetrics

Patient Name: DOB: Visit Date:

SYMPTOMS FOR PAST 4 WEEKS ONLY

Weight Loss:	O	Yes	O	No	Ear pain:	O	Yes	O	No
Decreased appetite:	O	Yes	O	No	Hearing loss:	O	Yes	O	No
Excessive Weight Gain	O	Yes	O	No	Dizziness:	O	Yes	O	No
Fatigue:	O	Yes	O	No	Sore Throat:	O	Yes	O	No
Fever:	O	Yes	O	No	Blurred vision:	O	Yes	O	No
Night Sweats:	O	Yes	O	No	Itching/Burning of eyes:	O	Yes	O	No
Gastrointestinal					Eye Pain:	O	Yes	O	No
Nausea:	O	Yes	O	No	Chronic Headaches:	O	Yes	O	No
Vomiting:	O	Yes	O	No	Neck Pain:	O	Yes	O	No
Abdominal pain:	O	Yes	O	No	Swollen lymph nodes:	O	Yes	O	No
Vomiting Blood:	O	Yes	O	No	**Cardiovascular**				
Gas:	O	Yes	O	No	Chest pain:	O	Yes	O	No
Bloating:	O	Yes	O	No	Palpitations:	O	Yes	O	No
Heartburn:	O	Yes	O	No	Murmur:	O	Yes	O	No
Trouble swallowing:	O	Yes	O	No	Swollen extremities:	O	Yes	O	No
Rectal Bleeding:	O	Yes	O	No	Abnormal Heart rhythm:	O	Yes	O	No
Change in bowel habits:	O	Yes	O	No	Tightness/Pressure:	O	Yes	O	No
Constipation:	O	Yes	O	No	**Respiratory**				
Diarrhea:	O	Yes	O	No	Shortness of Breath:	O	Yes	O	No
Endocrine					Chronic cough:	O	Yes	O	No
Change in Voice:	O	Yes	O	No	Coughing up blood:	O	Yes	O	No
Heat Intolerance:	O	Yes	O	No	Wheezing:	O	Yes	O	No
Cold Intolerance:	O	Yes	O	No	**Skin**				
Breast Changes:	O	Yes	O	No	Nail Changes:	O	Yes	O	No
Loss of Hair:	O	Yes	O	No	Rashes:	O	Yes	O	No
Extreme Thirst:	O	Yes	O	No	Color Changes:	O	Yes	O	No
Low Blood Sugar:	O	Yes	O	No	Itching/Dryness:	O	Yes	O	No
HEENT/Neck					**Hematologic**				
Nose Bleeds:	O	Yes	O	No	Easy Bruising:	O	Yes	O	No
Ringing in ears:	O	Yes	O	No	Anemia:	O	Yes	O	No
					Clotting problems:	O	Yes	O	No

Musculoskeletal			Kidney Stones:	O Yes	O No
Joint Pain:	O Yes	O No	Unusual color:	O Yes	O No
Swelling/Stiffness:	O Yes	O No	**Gynecological**		
Leg Cramps:	O Yes	O No	Bleeding between cycles:	O Yes	O No
Back Pain:	O Yes	O No	Vaginal discharge:	O Yes	O No
Weakness:	O Yes	O No	Night sweats:	O Yes	O No
Neurologic			Loss of libido:	O Yes	O No
Seizures:	O Yes	O No	Mood swings:	O Yes	O No
Loss of sensation:	O Yes	O No	Hot Flashes:	O Yes	O No
Trembling hands:	O Yes	O No	Painful intercourse:	O Yes	O No
Slurred speech:	O Yes	O No	Menstrual Flow:	O Light O Moderate	O Heavy
Tingling/Numbness:	O Yes	O No	Irregular Cycles:	O Yes	O No
Trouble with coordination:	O Yes	O No	Contraception:	O Yes	O No
Memory loss:	O Yes	O No	Breast pain/tenderness:	O Yes	O No
Lack of concentration:	O Yes	O No	Nipple Discharge:	O Yes	O No
Paralysis:	O Yes	O No	Lumps/Nodules:	O Yes	O No
Genitourinary			**Psychiatric**		
Urgent urination:	O Yes	O No	History of Mental illness:	O Yes	O No
Burning w/ Urination:	O Yes	O No	Anxiety:	O Yes	O No
Blood in urine:	O Yes	O No	Depression:	O Yes	O No
Incontinence:	O Yes	O No	Excessive Stress:	O Yes	O No
Discharge:	O Yes	O No	Trouble sleeping:	O Yes	O No
Frequent urination:	O Yes	O No	Panic Attacks:	O Yes	O No
Flank pain:	O Yes	O No	Suicidal Thoughts:	O Yes	O No

Surgical History NONE O (Please mark NONE if nothing below applies)

O Colonoscopy	O Hemorrhoidectomy	O Breast Cancer Surgery
O EGD(Upper endoscopy)	O Bypass Surgery	O Back Surgery
O Colon Surgery	O Heart Valve Replacement	O Hip Surgery
O Cholecystectomy	O Hysterectomy	O Knee Surgery
O Appendectomy	O Ovaries Removed	O Weight Loss Surgery

Past Medical History (Mark only those that apply or NONE) NONE O

O GERD/Heartburn	O Hypertension	O Fibromyalgia
O Ulcers	O Atrial Fibrillation	O Arthritis
O Colon Polyps	O Heart Attack	O Chronic Back pain
O Irritable Bowel Syndrome	O Congestive Heart Failure	O Cancer
O Hernia	O Pacemaker	O Renal Failure
O Hemorrhoids	O COPD	O Dialysis
O Diverticulosis	O Diabetes	O Sleep Apnea
O Pancreatitis	O Thyroid Problems	O Cataracts
O Crohn's Disease	O Elevated Cholesterol	O Glaucoma
O Ulcerative Colitis	O Stroke	O Marphan Syndrome

Family History Mark only those that apply or NONE

Parents O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease
O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Grandparents O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease
O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Siblings O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease
O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Children O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease
O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Social History

Marital status: O Married O Single O Divorced O Widowed O Life Partner

Occupation: O Full Time O Part Time O Retired O Homemaker O Student O Unemployed O Disabled

Who Lives with you: O Spouse O Children O Partner O Mother O Father O No one

Exercise: O Never O Daily O 1-2 times per week O 3-4 times per week

Caffeine use: O None O Daily O Occasionally

Tobacco use: O Yes O No O Trying to Quit O Previous smoker
If yes, Cigarette daily use: O ½ pack O 1 pack O 2 packs O more than 2 packs /day

Alcohol use: O Never O Daily O Social Drinker O Trying to Quit O Recovering Alcoholic

Illegal Drugs: O Yes O No O Recovering Addict

HIV infected: O Yes O No O Unknown (never been tested)