Kristin N. Schmidt, MD, PLLC

(Use blue or black ink only.)

Patient Name ____**Date of Birth**______________
Last First Middle

Address _____________________________________City/State/Zip _________________________

Telephone: Home (_____)_____________Work (_____)_____________ Cell (_____)____________

Email: _________________________ SS#______________ Check One: ___Single ___Married ___Other

Check One: ___Employed ___Student ___Unemployed Employer Name:__________________________

Ethnicity: ________________ Race: __________________ Language Spoken: _________________

Spouse/*Parent

Name________________________________ Wk Number____________________________

SS#_________________________________ Date of Birth___________________________

If the patient is a dependent child, please complete the information in the Spouse section for the parent

Emergency Contact:

Name______________________________ Relationship_________ Phone Number_____________

Insurance Information:

(Primary Insurance) *(Secondary Insurance)*

Ins Co ____________________________________ Ins Co _________________________________

Policy/ID# _________________________________ Policy/ID#______________________________

Group Number _____________________________ Group Number__________________________

Assignment of Insurance Benefits and Authorization to Release Information

I authorize payment of medical benefits to Kristin N. Schmidt, MD, PLLC for any and all services not paid in full at the time those services are rendered. I authorize to Kristin N. Schmidt, MD, PLLC release any medical information as necessary for the completion of my insurance claims to any insurance carrier, health or hospital plan. **Kristin N. Schmidt, MD, PLLC does not accept any form of Medicaid.**

Patient ____ Date _________________

Patient's Legal Guardian/Agent__________________________________ Date _________________

Date________________Name____Age____________

Reason for today's visit ____

What changes have there been in your life recently? ____

Date of last menstrual period ___________________________ Are they regular? _________________

Date of last Pap Smear___________________ Results ____

Date of last Mammogram _________________ Results ____

Date of last Bone Density _________________ Results ____

Date of last Colonoscopy _________________ Results ____

Any problems with periods? ____

Are you menopausal? ______________

Are you sexually active? ________ If yes, any difficulties or discomfort? _________________________

Do you want to change birth control?_________ If yes, to what? ________________________________

Are you trying to get pregnant? ___________ Problems conceiving? ____________________________

If not, preventative method (vasectomy, tubal, condoms, birth control, etc.) ____________________

With respect to your female organs, have you ever had: **(Circle all that apply)**

Abnormal bleeding   Chlamydia/Gonorrhea/Syphilis   Endometriosis   Herpes Infection

Infections of the Tubes or Ovaries   Tubal (Ectopic) Pregnancy   Tumor of the Uterus or Ovaries   Venereal Warts

Have you ever had an abnormal Pap Smear? ___________ When? ______________________________

Results: ____________________ Treatment: ____

Number of: ___Pregnancies___Deliveries ___Miscarriages ___Abortions___Living children

Please list previous pregnancies in chronological order:

MM/DD/YR	Sex	Wt/Length	Hrs in Labor	Anesthesia	Weeks at Delivery	Vag/Csec	Complications

Date________________Name____Age____________

Genetic: Have you or your husband been tested for the following? **(Circle all that apply)**

Sickle Cell Thalassemia Tay-Sachs BRACA Cystic Fibrosis

Other genetic disorder/carrier? ____

Current medication or Vitamins: **Strength:** **How Often:**

__________________________ ______________ ____

__________________________ ______________ ____

__________________________ ______________ ____

__________________________ ______________ ____

__________________________ ______________ ____

__________________________ ______________ ____

List all allergies to medications: __________________________ Reaction: ________________________

Pharmacy Name & Phone # ____

Past History: **(Circle all that apply)**

Allergies-Seasonal Anemia Arthritis Asthma Blood Clots (lungs or legs)

Breast Problems/Fibro Cystic Disease Cancer Diabetes: type 1 ___ type 2 ___ Gastric Reflux/Ulcers

Heart Attack/Heart Disease Heart Murmur/MVP Hepatitis High Blood Pressure High Cholesterol

Hyper/Hypothyroid Intestinal Bleeding Kidney Infection Kidney Stone Migraine Headaches

Mitral Valve Prolapse Neurological Disease/Stroke Osteoporosis/Osteopenia Paralysis

Pneumonia Rheumatic Fever Seizure/Epilepsy Thyroid Problems Thrombophlebitis

Other Diseases or Conditions: ____

____

Infectious Diseases (TB. HIV, Hepatitis)____

Will you permit a blood transfusion for medical reasons? ______________________________________

List all surgeries:

Type of surgery Approximate Date Type of surgery Approximate Date

1.____ 3.____

2.____ 4.____

5.____ 6.____

Date________________Name____Age____________

Social History: Race________________________ Occupation____________________________________

Do you drink alcohol? ________ If yes, estimated number of drinks per week _____________________

Do you smoke? ________ How many packs a day? __________

Are you using any other drugs? ________ If yes, what type? ____________________________________

Do you wear your seat belt? ______ Do you exercise ______ if yes, what type ______________________

Family History: Is there a member of your family with a history of: (Maternal or Paternal)

_______Arthritis Who? ____

_______Bleeding Disorder or Blood Clots Who? ____

_______Cancer—what type _____________________ Who? ___________________________________

_______Congenital (Inherited) Disease Who? ____

_______Diabetes/Type 1 or Type 2 Who? ____

_______Heart Disease Who? ____

_______High Blood Pressure Who? ____

_______High Cholesterol Who? ____

_______Kidney Disease Who? ____

_______Lupus/Rheumatoid Who? ____

_______Osteoporosis Who? ____

_______Mental Retardation/Autism Who? ____

_______Neurologic or Stroke Who? ____

_______Thyroid Problems (Hyper or Hypothyroidism) Who? __________________________________

_______Twins Who? ____