DAVID B. MCALPINE, M.D., F.R.C.S.

☐ INSURANCE ☐ SELF PAY

PATIENT'S NAME _____
LAST FIRST MI

ADDRESS _____
CITY STATE ZIP

HOME TELEPHONE NUMBER _____ CELL PHONE NUMBER _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ AGE _____

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOW

EMPLOYER _____ OCCUPATION _____

TELEPHONE NUMBER _____ EXTENSION _____

EMERGENCY CONTACT _____ TELEPHONE NUMBER _____

REFERRED BY _____

SPOUSE/GUARDIAN _____
LAST FIRST MI

ADDRESS _____
CITY STATE ZIP

HOME TELEPHONE NUMBER _____ CELL PHONE NUMBER _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

EMPLOYER _____

TELEPHONE NUMBER _____ EXTENSION _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

INSURED'S NAME _____ GROUP #/POLICY # _____

SECONDARY INSURANCE _____

INSURED'S NAME _____ GROUP #/POLICY # _____

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I ALSO CONSENT FOR DR. MCALPINE TO TREAT ME.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

PLEASE NOTE: PAYMENT IS DUE AT THE TIME OF SERVICE. OUR OFFICE DOES ACCEPT VISA, MASTERCARD, DISCOVER, CHECKS AND CASH. WE ARE PROVIDERS FOR MOST HMO'S AND PPO'S. PLEASE GIVE CARD TO RECEPTIONIST FOR PROPER BILLING AND TO AVOID PAYMENT DELAY.

DAVID B. MCALPINE, M.D., F.R.C.O.G.

7100 Oakmont Blvd., Suite 102
Fort Worth, Texas 76132
817-370-2440 817-370-8209 FAX

Patient's Printed Name _____

Date of Birth _____

Social Security # _____

I CONSENT AND AUTHORIZE THE RELEASE OF PERSONAL/MEDICAL INFORMATION TO THE FOLLOWING PERSONS:

My Spouse _____

My Child(ren) _____

_____

_____

My Parent(s) _____

_____

Signature _____

Date _____

DAVID B. McALPINE, M.D., F.R.C.O.G.
7100 Oakmont Blvd. – Suite 102
Fort Worth, Texas 76132

Gynecology Health History

ID No.:_____

Today's Date:_____ / _____ / _____

PATIENT IDENTIFICATION *(Please print)*

Patient's Name:_____

Address:_____

_____

Home Telephone No: ( )_____

Work Telephone No: ( )_____

Reason for Seeing Doctor_____

Date of Birth: ____ / ____ / ____ Age: _____ Religion: _____

Marital Status: ❑ S ❑ M ❑ D ❑ SEP ❑ W Race: _____

Education:_____ years Occupation:_____

Employer:_____

Type of Insurance:_____ Policy #: _____

Referring Physician: _____

Primary Physician: _____

1. CURRENT MEDICATIONS ❑ None

_____

_____

_____

2. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to: ❑ None

_____

_____

_____

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:	You	Your Family
3. High Cholesterol	❑	❑
4. Heart Disease	❑	❑
5. Rheumatic Fever	❑	
6. High Blood Pressure	❑	❑
7. Asthma	❑	
8. Tuberculosis	❑	
9. Diabetes	❑	❑
10. Thyroid Problems	❑	❑
11. Liver Disease	❑	
12. Stomach, Bowel or Gall Bladder Problems	❑	
13. Kidney or Bladder Problems	❑	
14. AIDS (HIV)	❑	❑
15. Hepatitis (type ___)	❑	❑
16. Anemia or Blood Disorder	❑	❑
17. Blood Transfusion	❑	
18. Allergies	❑	
19. Breast Problems	❑	❑
20. Cancer	❑	❑
21. Infertility	❑	
22. Female or Sexual Problems	❑	
23. Chlamydia	❑	
24. Gonorrhea	❑	
25. Herpes (HSV)	❑	
26. Syphilis	❑	
27. Birth Defects or Inherited Diseases	❑	❑
28. Sexual Abuse or Domestic Violence	❑	❑
29. Other Medical Problems	❑	❑
30. **No Known Medical Problems**	❑	❑

31. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ❑ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications Yes	No
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ❑
Type _____
Amt/day _____

33. Tobacco ❑
Type _____
Amt/day _____

34. Caffeine ❑
Type _____
Amt/day _____

35. Non-Prescribed Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

36. Street Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

37. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term= 40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	No
1	/		lbs. oz.					❑	❑
2	/		lbs. oz.					❑	❑
3	/		lbs. oz.					❑	❑
4	/		lbs. oz.					❑	❑
5	/		lbs. oz.					❑	❑

38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____/____/____

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ❑ Excessive Bleeding ❑ Discharge ❑ Pain ❑ None

39. CONTRACEPTIVE HISTORY

Type	Dates Used
Oral Contraceptive ❑	_____
Type(s) _____ ❑	_____
_____ ❑	_____
IUD ❑	_____
Diaphragm ❑	_____
Norplant ❑	_____
Sponge ❑	_____
Spermicide ❑	_____
Condoms ❑	_____
Other _____ ❑	_____

Sterilization ❑ Male ❑ Female

LIFESTYLE

	Yes	No
40. Did your mother take DES or any other hormones when pregnant with you?	❑	❑
41. Have you ever had a Pap test?	❑	❑
If Yes: Date of your last Pap test? ___/___/___		
Have you ever had abnormal Pap test results?	❑	❑
42. Are you sexually active?	❑	❑
43. Do you have one partner or	❑	one
many partners	❑	many
44. Is intercourse painful for you?	❑	❑
45. Do you do a monthly self breast exam?	❑	❑
46. Have you ever had a mammogram?	❑	❑
If Yes: Date of your last mammogram? ___/___/___		
47. Do you exercise on a regular basis?	❑	❑
If Yes: Type of exercise _____		
Hours per week exercise _____		

Check and detail positive findings below. Use reference numbers.

Signature: _____