GARY H. GOLDMAN, M.D.
OBSTETRICS & GYNECOLOGY
(212) 535-6100
715 Park Avenue, New York, NY 10021

Print Form

For office use only:

Office Account # _____

NYPH # _____

Name (First, Last, MI) _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Daytime Phone ( ) _____

Cell Phone ( ) _____ E-mail _____

Age _____ Date of Birth _____ Social Security _____

Marital Status _____ Religion _____ Race _____

Occupation _____ Employer _____

Father's Name _____ Mother's Name _____

Insurance Company _____ Policy # _____

Policy Holder's Name _____ Policy Holder's SS _____

Who may we thank for referring you? _____

In an emergency, who should we contact?

Name _____

Relation _____ Daytime Phone _____

Home Phone _____ Cell Phone _____

Occupation _____ Employer _____

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Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the Insurance Company: _____ and assign directly to Dr. Gary Goldman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payable by insurance. I hereby authorize Dr. Goldman to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date

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Name _____ Date _____

Medical Illnesses	Self	Family	Comment
Diabetes	☐	☐	
Thyroid Disease	☐	☐	
High blood pressure	☐	☐	
Heart attack	☐	☐	
Stroke	☐	☐	
High Cholesterol	☐	☐	
Mitral Valve Prolapse/ Heart Murmur	☐	☐	
Rheumatic Fever	☐	☐	
Cancer	☐	☐	
Asthma	☐	☐	
Pneumonia	☐	☐	
Tuberculosis	☐	☐	
Kidney Disease (Stone, Infection, …)	☐	☐	
Liver Disease (Hepatitis, …)	☐	☐	
Seizures, Epilepsy	☐	☐	
Migraines	☐	☐	
Eye Diseases, Glaucoma	☐	☐	
Blood Diseases (Sickle Cell, Thalassemia, …)	☐	☐	
Bleeding Disorders (von Willebrand's, …)	☐	☐	
Thrombophilias (Leyden Factor, …)	☐	☐	
Varicose Veins, Phlebitis, DVT	☐	☐	
Blood Transfusion	☐	☐	
Major Trauma/ Fractures	☐	☐	
Celiac Sprue	☐	☐	
Ulcers	☐	☐	
Diverticulosis, Diverticulitis	☐	☐	
Irritable Bowel Syndrome	☐	☐	
Ulcerative Colitis, Crohn's Disease	☐	☐	
Psychiatric Disorder	☐	☐	
Genetic Disorder (Down's Syndrome, …)	☐	☐	
Osteopenia/Osteoporosis	☐	☐	
	☐	☐	
	☐	☐	

ALLERGIES (Include reaction, if known) :

MEDICATIONS

Name	Dose	Indication

PAST SURGICAL HISTORY

Date	Procedure	Indication	Surgeon	Location

SOCIAL HISTORY

Cigarettes: ☐ Never smoked Quit: in which year
☐ Use Currently # Years Smoking # Cigarettes/Day

Alcohol: Average # Drinks/ week
How many drinks does it take to make you feel high?
Have people annoyed you by criticizing your drinking?
Have you felt you ought to cut down on your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Drugs: Do you currently ☐ or have you ever ☐ used intravenous drugs?
If Yes, specify:
Do you currently ☐ or have you ever ☐ used any other drugs?
If Yes, specify:

Toxin Does your job or any other activity expose you to any toxic substances that Exposures:
you know about? If you can, specify:

OBSTETRICAL HISTORY

Total # of pregnancies Total # of living children # Full-term (> or = 36 weeks) # Pre-term(<36 weeks)
Ectopics # Abortions # Abortions # Multiple pregnancies (twins, …)

Date	Infant's				Hours in labor	Delivery type	Complications
	Sex	Birth Wt.	Full Term?	Alive?			

GYNECOLOGICAL HISTORY

Menstrual History

date of first day of last menstrual period ____ prior menstrual period ____

age at onset of your periods ____ age at your mother's menopause ____

usual cycle length (# days from the beginning of one flow until the next flow) ____

☐ irregular cycles: range of cycles ____ usual # days of flow ____

☐ very heavy flow ☐ very painful periods ☐ bleeding between periods

Menopausal History

age at your menopause ____ ☐ hormone use after menopause: (☐ currently ☐ in the past)

☐ vaginal dryness ☐ hot flashes/night sweats ☐ bleeding after menopause

Venereal Diseases

☐ gonorrhea ☐ syphilis ☐ chlamydia ☐ PID ☐ herpes: ☐ oral &/or ☐ genital ☐ HPV/ genital warts/ condyloma

☐ other: ____

Pap Smears

date of last pap smear ____ results: ____ ☐ history of abnormal pap ☐ prior colposcopy

☐ prior cone biopsy, laser, cryosurgery, LEEP or local acids to treat abnormalities of cervix or vulva

Urinary Tract Problems

☐ UTI/ bladder infection/ cystitis ☐ incontinence ☐ hematuria/ blood in urine

☐ kidney infection/pyelonephritis ☐ kidney stones ☐ interstitial cystitis

Breast Health

year of last mammogram ____ results: ☐ normal ☐ other ____

have you had a breast sonogram : ☐ no ☐ yes - results: ____

have you had a breast MRI: ☐ no ☐ yes - results: ____

☐ fibrocystic ☐ mass/ lump ☐ cyst ☐ pain ☐ persistent lymph node swelling

☐ nipple discharge ☐ any new change in appearance or other concern: ____

Sexual Health

☐ virgin ☐ currently active (within the last year) ☐ not active for > one year

☐ male partner(s) ☐ female partner(s) ☐ current # partners ____ lifetime # partners ____

problems with : ☐ pain ☐ bleeding ☐ penetration ☐ orgasms ☐ libido ☐ lubrication

☐ other ____

Contraception

	pill	diaphragm	IUD	condoms	sterilization	other: ____	____
currently use:	☐	☐	☐	☐	☐	☐	☐
previously used:	☐	☐	☐	☐	☐	☐	☐

Other GYN Health Concerns

☐ endometriosis ☐ fibroids ☐ infertility ☐ DES exposure ☐ ovarian cysts

☐ date of last bone density study ____ results: ☐ normal ☐ osteopenia ☐ osteoporosis

☐ date of last colonoscopy ____ results: ☐ normal ☐ other: ____

☐ anorexia/bulimia ☐ any additional concerns: ____

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Additional Comments