COASTAL GYNECOLOGY
1744 Sir William Osler Dr
Virginia Beach, VA 23451
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Morris M. Elstein, MD
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NAME: ______________________________ DATE: ______________

ADDRESS: ______________________________ CITY & ZIP: ______________

HOME PHONE: ____________ CELL PHONE: ____________ DATE OF BIRTH: ____________

SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____ SOCIAL SECURITY # ____________

PRIMARY CARE PHYSICIAN: ______________________________

PHARMACY NAME/ADDRESS: ______________________________ PH #: ____________

REFERRING PHYSICIAN OR REFERRING FRIEND: ______________________________

PATIENT'S EMPLOYER: ______________________________ WORK PHONE: ____________

EMPLOYER ADRESS: ______________________________

SPOUSE OR PARENT (CIRCLE ONE): ______________________________CELL #____________

SECURE TEXT MESSAGING: YES ______ NO ______

PATIENT PORTAL: YES _____ NO _____ EMAIL ADDRESS ______________________________

Would you like to be added to our **COASTAL 757 AESTHETICS** Email list? YES ______ NO ______

NEAREST RELATIVE OR NEIGHBOR FOR EMERGENCIES (NOT LIVING WITH YOU)

NAME: ______________________________ RELATIONSHIP:____________

ADDRESS: ______________________________ PHONE NUMBER: ____________

INSURANCE INFORMATION:

COMPANY NAME: ______________________________ EFFECTIVE DATE: ____________

POLICY/SUBSCRIBER #: ______________________________ GROUP #: ____________

SUBSCRIBER'S NAME: ______________________________ SUBSCRIBER'S DATE OF BIRTH: ____________

SECONDARY OR SUPPLEMENTAL INSURANCE NAME: ______________________________

POLICY/SUBSCRIBER #: ______________________________ GROUP #:____________

MAIN REASON FOR TODAY'S VISIT: ____

____

ALLERGIES: List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
______________________	______________________
______________________	______________________
______________________	______________________

MEDICATIONS: List all medications you are taking including over-the-counter drugs, vitamins, etc.

NAME	DOSE	FREQUENCY
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

Medication History Authorization: Yes ____ No ____

IMMUNIZATION HISTORY: (Most recent date)

Flu shot	Date: ____________	Pneumonia	Date: ____________
Tdap (Tetanus and pertussis)	Date: ____________	Gardasil/HPV	Date: ____________
Zostavax (Shingles)	Date: ____________	Shingrix (Shingles)	Date: ____________

SURGICAL HISTORY:

SURGERY	REASON	DATE
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________

PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

	Y/N	NOTES		Y/N	NOTES
ADHD	____	__________	Genitourinary Disease	____	__________
Abuse/Domestic Violence	____	__________	HIV or AIDS	____	__________
Anemia	____	__________	Headaches	____	__________
Anesthesia Complications	____	__________	Hematologic Disease	____	__________
Anxiety Disorder	____	__________	Hepatic/Liver Disease	____	__________
Arrhythmia	____	__________	High Cholesterol	____	__________
Arthritis	____	__________	High Blood Pressure	____	__________
Asthma	____	__________	Hypothyroidism	____	__________
Bipolar	____	__________	IBS	____	__________
Birth Defects/Disease	____	__________	Immunologic Disorder	____	__________
Breast Cancer	____	__________	Kidney Stones	____	__________
Breast Disease	____	__________	Menopause	____	__________
Cancer	____	__________	Migraines	____	__________
Cardiovascular Disease	____	__________	Multiple Sclerosis	____	__________
Cerebrovascular (Stroke)	____	__________	Musculoskeletal Disease	____	__________
Colon polyp	____	__________	Neurologic Disorder	____	__________
Coronary Artery Disease	____	__________	Obesity	____	__________
Deep Venous Thrombosis	____	__________	Osteoporosis/Osteopenia	____	__________
Depression	____	__________	Ovarian Cancer	____	__________
Dermatologic Disorder	____	__________	Psychiatric Illness	____	__________
Diabetes Mellitus	____	__________	Pulmonary/Lung Disease	____	__________
Diverticulitis	____	__________	Renal/Kidney Disease	____	__________
Ear or Hearing Disorder	____	__________	Seizures/Epilepsy	____	__________
Eating Disorder	____	__________	Sleep Apnea	____	__________
Eczema or Acne	____	__________	Substance Abuse/Depen	____	__________
Endocrine Disorder	____	__________	Thrombophilias	____	__________
Fibromyalgia	____	__________	Thyroid Disease	____	__________
Gastroesophageal Reflux	____	__________	Urologic Disorder	____	__________
Gastrointestinal Disease	____	__________	Vision/Eye Disorder	____	__________
Genetic/Hereditary	____	__________	Vitamin D Deficiency	____	__________

SOCIAL HISTORY:

Tobacco Smoking Status: Never Smoker:______ Former Smoker: _____ Current Smoker: _____
How Much: ______________________

Smokeless Tobacco Status: Never used: ____ Former Smoker: ____ Current Smoker: ____

Tobacco years of use: _______________Years

E-cigarette/Vape Status: Never used: ____ Former User: ____ Current user: ______

Alcohol intake: None ______ Occasional ______ Moderate ______ Heavy ______

Advance Directive: Yes ____ No ____

Marital Status: Married ____ Single ____ Divorced ____ Separated ____ Widowed ____

Number of Children: __________

Do you feel safe in your current relationship: Yes ____ No ____

Sexual orientation: Lesbian _____ gay or homosexual ______ Straight or Heterosexual ______

Bisexual ____ Something else, please describe ____

Are you working: Yes _______ No ________ Occupation: ______________________________

Recreational (illicit) Drugs: Yes_________ No ________

GYN HISTORY:

Date of LMP: ____________ (What was the first day of your last menstrual cycle)

Frequency of cycle __________ Duration of Flow ________

Flow: Light ______ Moderate ________ Heavy ________

Monthly Menses: Yes _____ No ______ Menstrual Cramps: Mild ____ Moderate ____ Severe ____

Premenstrual Syndrome: Yes ____ No ____

Date of Last Pap Smear: ____________

Date of HPV Testing: ___________ HPV testing results: Positive ____ Negative ____

Abnormal Pap: Yes ____ No ____

Abnormal Pap Smear Results: ASC-US ____ ASC-H ____ LSIL ____ HSIL ____ AGC ____

Colposcopy: ____________

Any treatment for Abnormal Pap: Yes _____ No ____

Age at menarche (When you first started having periods) ________

If post menopausal, age at menopause: ________

Have you had the HPV vaccine series? Yes ______ No ______

Number of lifetime sexual partners: ______ Number of sexual partners in the past 12 months ______

Sexually Active: Yes ____ No ____ Protected Sex: Always ____ Usually ____ No ____
Sexual Problems: Yes ____ No ____ Note: ____

STIs/STDs (Gonorrhea, Chlamydia, Genital Warts, Herpes): Yes ____ No ____

If yes, please list ____

Current birth control method: ______________________

Desired birth control method: ______________________

Date of Last mammogram: __________ Mammogram Results: Normal ____ Abnormal ____

Most Recent Bone Density: __________

Date of Last Colonoscopy: ___________ Followup years: _______

Endometriosis: Yes ____ No ____ Fibroids: Yes ____ No ____

Infertility: Yes ____ No ____ Ovarian Cysts: Yes ____ No ____

PCOS: Yes ____ No ____

OB HISTORY: Total # of Pregnancies: ____ Full term: ____ Preterm: ____ Abortions: ____
Miscarriages: ____ Ectopics: ____ # of Living children: ____

DELIVERY DATES	VAGINAL OR C-SECTION	BABY'S WEIGHT	COMPLICATIONS
____________	________________	___________	_________________
____________	________________	___________	_________________
____________	________________	___________	_________________
____________	________________	___________	_________________

FAMILY HISTORY:

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	___	________________________________
Grandfather (maternal)	Y/N	___	________________________________
Grandmother (paternal)	Y/N	___	________________________________
Grandfather (paternal)	Y/N	___	________________________________
Mother	Y/N	___	________________________________
Father	Y/N	___	________________________________
Sister	Y/N	___	________________________________
Brother	Y/N	___	________________________________

I understand payment is due on the date of visit, including any insurance co-payments.

I agree to be financially responsible for the cost of all medical and/or surgical services rendered to the patient by Dr. Morris Elstein. The cost of these services shall be in accordance with the usual and customary charges for such services.

If payment for these services is not made when agreed upon, I agree to pay, in addition to the physician's fee, all costs of collecting the amount due with interest from the due date, including attorney's fees of $33^{1/3}$% of the amount due or collection agency fees that may be up to 50% of the amount due, and all court costs expended in the collection of this medical bill.

I understand that if I am a no show for an appointment there will be a 50.00 fee. You must call before your appointment to not be charged this.

I also hereby authorize the release of medical records to any company insuring the below patient in accordance with HIPPA guidelines and assign all benefits from insurance to Dr. Morris M. Elstein, MD. and/or Coastal Gynecology for professional services provided.

By signature, I acknowledge that I have read and understand the terms of this agreement.

Date: ______________ Signature: ____

HIV Disclosure:

A law was enacted in Virginia in 1989 that authorizes health care providers to test their patients for HIV antibodies when the health care provide is exposed to body fluids of a patient in a manner that may transmit human immunodeficiency virus (HIV – "AIDS" Virus). In the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider, who may have been exposed. You will be offered the opportunity for a face-to-face disclosure of the results of the HIV test and counseling. By my/our signature, I/we have read and understand the terms of the agreement as well as the notice of deemed consent to HIV blood testing.

______________________________	______________________________
Patient Signature	Guarantor Signature
______________________________	______________________________
Date	Witness

If you would like to receive text messages please circle yes below. If you are interested in Patient Portal please provide us with your email address and we will send you the information to sign up with our office. Your email address will be protected and will not be knowingly disseminated to any individuals or companies. It is your responsibility to inform our office of any changes in your email address. This service enables our office to contact you about the above mentioned services in a more effective, cost savings manner. If you have any questions or concerns about this service, please ask any of our office staff.