Asheville Obstetrics
& Gynecology

# Patient Update Form

Date_____

Name _____ Name I Prefer_____

Last First Middle Maiden Name

SSN _____ Date of Birth _____ Age _____ Gender: Female/ Male/ Other

Race _____ Are you Hispanic? Yes / No Preferred Language _____

Address _____ City _____ State_____ Zip _____

Home Phone ( )_____ Work ( )_____ Cell ( )_____

Email Address_____ Employer _____

Marital Status _____ Spouse/Partner's Name _____ Cell ( ) _____

Spouse/Partner Employer _____ Work Phone ( ) _____

Emergency Contact Name _____ Phone ( ) _____

Relationship to Patient _____

Primary Insurance Co. _____Policyholder's Name _____

Date of Birth _____ SSN _____ Relationship to Patient _____

Policy # _____ Group # _____

Other Insurance Information _____

***Current Medications (include birth control medications, supplements and herbs)

PLEASE LIST MEDICATION AND DOSAGE:

_____

_____

_____

Pharmacy Name _____Location/Phone_____

Primary Care Physician _____

***First Day of Last Period _____ Any problems with periods? _____

Drink alcohol? _____ How many drinks a day? _____ A week? _____

Use Drugs ? _____ If yes, what kind? _____ How often? _____

Do you smoke? _____ How many a day? _____

New medical problems _____ New Allergies _____

Surgeries since last visit _____

Date of last mammogram _____ Date of last colonoscopy _____

Date of last bone density test _____ Date of last labs/bloodwork _____