



# 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 \_\_\_\_\_