

**Eastside Gynecology**

P.O. Box 325 / 1580 Tree Lane \* Snellville, Georgia 30078

Phone: (770) 978-7246 \* Fax: (770) 979-8348

Robert E. Kelley, M.D.

**REQUEST FOR RECORDS FROM ANOTHER PHYSICIAN/FACILITY**

**OR**

**REQUEST FOR RELEASING RECORDS FROM ANOTHER PHYSICIAN/FACILITY**

*(Note: Form MUST be completed before signature is obtained)*

Patient's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

\_\_\_\_\_ **I AUTHORIZE THE PHYSICIAN/FACILITY LISTED BELOW TO  
RELEASE MY RECORDS TO EASTSIDE GYNECOLOGY**

\_\_\_\_\_ **I AUTHORIZE EASTSIDE GYNECOLOGY TO RELEASE MY  
RECORDS TO THE PHYSICIAN/FACILITY LISTED BELOW**

Physician or Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_

I request all medical records unless specified: \_\_\_\_\_

**I understand (or person authorized to consent for patient) and hereby authorize the release of records from the physician/facility stated above or authorize the release of records to another physician/facility. I understand this authorization includes release of all medical records and protected health information.**

Signature of patient or patient's representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of patient's representative: \_\_\_\_\_

Relationship to the patient/ or authority to Act for the patient: \_\_\_\_\_

# Athens/Eastside Gynecology

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth (DOB): \_\_\_\_\_ Race: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: (Circle) S M D W Spouse's Name: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Referred by: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Insurance # 1: Name of Insurance: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Insurance # 1: Name of Insurance: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Athen's Gynecology, P.C. has a signed contract with my insurance, provisions of the contract will be followed. Otherwise, charges for office visits are due at the time of service. Deductions, co-insurance, co-pays, non-covered services, and all other balances not covered by insurance are my responsibility.

For your convenience, if your check is returned for any reason, an electronic debit will be made to your checking account for the amount of your check plus a processing fee up to the state limit.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party if patient is under 18: Name: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Athens/Eastside Gynecology

Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. What is the reason for your visit today? \_\_\_\_\_

2. List current medications and dosage: \_\_\_\_\_  
\_\_\_\_\_

3. List Drug Allergies: \_\_\_\_\_

List Other Allergies: \_\_\_\_\_

4. List any medical problems (i.e. high blood pressure, diabetes, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Since your last exam, have you had any problems with: YES NO

- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Your Menstrual Cycles                    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Irregular Bleeding                       | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cramps                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Abnormal Vaginal Discharge               | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Pelvic / Abdominal Pain                  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Breast Changes                           | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Change in Bowel Habits                   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Urinary Burning, Frequency, Incontinence | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Emotional Stress                         | <input type="checkbox"/> | <input type="checkbox"/> |

6. Since your last visit have you had any: YES NO

- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Medical Problems                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Surgeries                            | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Sexual Problems                      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Change in Family History             | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Plans to Attempt Pregnancy this Year | <input type="checkbox"/> | <input type="checkbox"/> |

7. Have you been vaccinated in the last year against: YES NO

- |                                 |                          |                          |
|---------------------------------|--------------------------|--------------------------|
| a. Diphtheria-Pertussis-Tetanus | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tetanus-Diphtheria Booster   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Polio                        | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Rubella                      | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hepatitis B                  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Influenza / Flu Shot         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Chicken Pox                  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Pneumonia                    | <input type="checkbox"/> | <input type="checkbox"/> |

8. Do you smoke? \_\_\_\_\_ Do you use alcohol? \_\_\_\_\_

# Athens/Eastside Gynecology

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_

Referred by: \_\_\_\_\_

## Family History

	Living		Deceased	
	Age	Health	Age	Cause of Death
Father				
Mother				
Brothers / Sisters				
Husband				
Sons / Daughters				

Has any relative ever had:	NO	YES	WHO
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cesarean Section	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Menstrual History

Age of Onset: \_\_\_\_\_ Regular:  Yes  No

Cycle: \_\_\_\_\_ days (from start to start) Usual Duration: \_\_\_\_\_ days

Flow:  Light  Heavy  Moderate Pains or Cramping:  Yes  No

Date of Last Period: \_\_\_\_\_ Birth Control: \_\_\_\_\_

# Athens/Eastside Gynecology

List Pregnancies (Include Miscarriages)

Year	Weight	Sex	Hours of Labor	Anesthesia	Complications

Have you ever had:	NO	YES	Do you now have or ever had:	NO	YES
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Any Eye Disease, Injury, Impaired Sight	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Any Ear Disease, Injury, Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Any Trouble with Nose, Sinuses, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Any Head Injuries, Fainting Spells, Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Polio or Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Spitting up of Blood	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infections	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis or Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands, feet, or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion, Stomach Trouble, Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding, Constipation, Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Urine with Cough or Sneeze	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			

Alcoholic Beverages:    Never    Moderate    Daily

Cigarettes: \_\_\_\_\_ How many packs per day: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Blood Transfusions:    No    Yes   How Many: \_\_\_\_\_

Allergies: \_\_\_\_\_

What medications are you taking now: \_\_\_\_\_

\_\_\_\_\_