VYTALISE

Patient Name: ________________________________ DOB: __________
Last First Middle
Today's Date: __________________________; MRN: _______________

Person Filling this Application Name: _____________________________

Patient Information

Name: ____ Date: _____________

Address: ____

Home / Cell Phone: _______________________ Email: ________________________________

Social Security #: ________-________-________ DOB: ____________________

Government ID Type: ________________ Number: ____________________ Exp.: ____________________

Primary Care Physician

Name: ____________________________________ Telephone #: _________________________
Address: ____
Address City State Zip

Insurance Information

Insurance Name: ____________________________ Subscriber I.D.: ___________________________
Group Policy Number: ____________________________

Employer Information *[ ] Currently Employed [ ] Unemployed[ ] Retired [ ] Legally Disabled*

Company Name: _________________________________ Telephone #: __________________________
Address: ____
Address City State Zip

Emergency Contact

Name: _________________________ Phone #: _________________ Relationship: _________________
Address: ____
Address City State Zip

Preferred Pharmacy

Name: ___________________________________ Telephone #: ________________________________
Address: ____
Address City State Zip

720 Alamitos Ave
Long Beach, CA-90813

Contact@Vytalise.com
www.Vytalise.con

Tel: (562) 546-2496
Fax: (562) 546-2794

Patient Name: ________________________________ *DOB:* __________
Last *First* *Middle*
Today's Date: __________________________; *MRN:* _______________

Person Filling this Application Name: _____________________________

Please complete all fields:

Patient Medical History: (Medical Problem/ Date Diagnosed)

____ Resolved ☐ Yes ☐ No
____ Resolved ☐ Yes ☐ No
____ Resolved ☐ Yes ☐ No
____ Resolved ☐ Yes ☐ No
____ Resolved ☐ Yes ☐ No
____ Resolved ☐ Yes ☐ No

Patient Surgical History: (Surgery/ Date/ Reason)

____
____
____
____
____
____

List Allergies (Medications, food and products):

____
____

MEDICATION LIST (name of & amount taken/day):

1.____
2.____
3.____
4.____
5.____

Family History:

1.____
2.____
3. Personal or Family Hisotry of Blood Clots or use of blood thinners, Pleas elaborate _______________
____
____

Patient Social History:

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

Occupation ___________________________________

Do you smoke? ☐ Yes ☐ No If yes, how many per day & years? __________

Do you use any street drugs? ☐ Yes ☐ No Specify: __________

Do you drink during pregnancy? ☐ Yes ☐ No If yes, how much? ________________________

Do you/others have concerns about your drinking? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? _________________

Domestic Violence/ Abuse? ☐ Yes ☐ No If yes, explain: __________________________________

Patient Gynecological History:

Age at first period ____________________ Regular ☐ Yes ☐ No

Frequency of periods (in days) ___________________ Duration (in days) ____________________

Amount: ☐ Light ☐ Moderate ☐ Heavy: Number of pads per day: ________________

Are you currently sexually active? ☐ Yes ☐ No How long with current partner? ___________

Unusual Vaginal Discharge ☐ Yes ☐ No Unusual itching/odor ☐ Yes ☐ No

Method of Birth Control used: ____

Trouble Getting Pregnant: ☐ Yes ☐ No

Have you ever had an STD? ☐ Yes ☐ No If yes, which infection? __________________________

Date of Last Pap-smear: _____________________ Abnormal Pap-smear ☐ Yes ☐ No

Abnormal Colonoscopy ☐ Yes ☐ No Date of Last Colonoscopy: ___________________

Abnormal Mammogram ☐ Yes ☐ No Date of Last Mammogram: _________________

Patient Past Obstetrical History:

Number of Pregnancies: ____ Number of Abortions: ____ Number of Miscarriages: ____ Ectopic: ____

Have you had Cesarean section: ☐ Yes ☐ No If yes how many: ___________________

Have you had vaginal delivery after Cesarean section: ☐ Yes ☐ No If yes how many: ___________________

Have you had Vacuum or Forceps Deliveries: ______________ Have you had Epidural: ___________________

Did you develpe Pre-Eclampsia or Diabeties in previous Pregnancy? : ☐ Yes ☐ No If yes, please specify:

____

Previous pregnancies (in order including miscarriages and abortions)**:**

#	Date (Month/Yr)	Gestational Age	Length of labor	Weight of baby	Sex (M/F)	Type of Delivert	Place of Labor	Complications& Comments

Other Complication(s) during Last Pregnancy(S): ____

____

Blood Transfusion: ☐ Yes ☐ No if yes, how many units and dates: _________________________

Is Blood Transfusion acceptable to you: ☐ Yes ☐ No If No, why: ___________________________

Do you have any of the followings?

Anesthetic Complications:	☐ Yes	☐ No	Thyroid Dysfunction:	☐ Yes	☐ No
Rh (D) Sensitized (-ve blood type):	☐ Yes	☐ No	Uterine Anomalies:	☐ Yes	☐ No
Pulmonary T.B.:	☐ Yes	☐ No	Trauma/ Injury:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No	Domestic Violence:	☐ Yes	☐ No
Auto Immune Disorder:	☐ Yes	☐ No	Psychiatric Disorders:	☐ Yes	☐ No
Epilepsy/ Neurological Disease:	☐ Yes	☐ No	Heart Disease:	☐ Yes	☐ No
Kidney Disease:	☐ Yes	☐ No	Hypertension:	☐ Yes	☐ No
Hepatitis/ Liver Disease:	☐ Yes	☐ No	Diabetes:	☐ Yes	☐ No
Varicosities/ Phlebitis:	☐ Yes	☐ No			

Personal, Family history, Partner History or Partner's Family history of:

Age above 35:	☐ Yes	☐ No	Cystic Fibrosis:	☐ Yes	☐ No
Thalassemia:	☐ Yes	☐ No	Huntington Chorea:	☐ Yes	☐ No
Neural Tube Defect:	☐ Yes	☐ No	Mental Retardation/ Autisim:	☐ Yes	☐ No
Congenital Heart Disease:	☐ Yes	☐ No	Metabolic Disorder (PKU):	☐ Yes	☐ No
Down Syndrome:	☐ Yes	☐ No	Recurrent Pregnancy Loss:	☐ Yes	☐ No
Tay Sacks:	☐ Yes	☐ No	Stillbirth (Baby Born Dead):	☐ Yes	☐ No
Sickle Cell Disease/ Trait:	☐ Yes	☐ No	Others Inherited/ Chromosomal Dis.:__________		
Hemophilia:	☐ Yes	☐ No	____		
Muscular Dystrophy:	☐ Yes	☐ No			

Infections History:

Travel to area infected with Zika Virust:	☐ Yes	☐ No
Positive T.B. Test in past:	☐ Yes	☐ No
Live with someone with T.B.:	☐ Yes	☐ No
Rash or Viral Illness:	☐ Yes	☐ No
Genital Herpis:	☐ Yes	☐ No
History of Hepatitis:	☐ Yes	☐ No
History of Syphilis :	☐ Yes	☐ No
History of HIV:	☐ Yes	☐ No
Intercourse with person with HIV:	☐ Yes	☐ No
Other STD:	☐ Yes	☐ No
Other Infections:	☐ Yes	☐ No; ____

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Are you currently having any problems related to the following systems? Circle Yes or No

Constitutional Symptoms

Fever ↑	☐ Yes	☐ No
Chills ↑	☐ Yes	☐ No
Weight Loss/Gain	☐ Yes	☐ No

Allergic/Immunologic

Food Allergies↑	☐ Yes	☐ No
Drug Allergies↑	☐ Yes	☐ No

Endocrine

Excessive Thirst	☐ Yes	☐ No
Too hot/cold ↑	☐ Yes	☐ No
Tired/Sluggish↑	☐ Yes	☐ No

Cardiovascular

Chest Pain ↑	☐ Yes	☐ No
Blood Clotting Problem	☐ Yes	☐ No
Swelling Legs ↑	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No

Respiratory

Wheezing	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

Breast

Breast Pain	☐ Yes	☐ No
Nipple Discharge	↑☐ Yes	☐ No
Breast Lumps	☐ Yes	☐ No

Neurological

Headaches	☐ Yes	☐ No
Dizzy Spells ↑	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No

Eyes

Blurred Vision	☐ Yes	☐ No
Double Vision ↑	☐ Yes	☐ No

Gastrointestinal

Abdominal Pain	☐ Yes	☐ No
Nausea/Vomiting	↑☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No

Integumentary (skin)

Skin Rash	☐ Yes	☐ No
Boils ↑	☐ Yes	☐ No
Persistent Itch	☐ Yes	☐ No

Psychologic

General Satisfaction with your life	☐ Yes	☐ No
Severe Depression	↑☐ Yes	☐ No
Considering Suicide	☐ Yes	☐ No

Genitourinary

Urine Retention	☐ Yes	☐ No
Painful Urination	↑☐ Yes	☐ No
Urinary Frequency	↑☐ Yes	☐ No

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List your concerns regarding the current pregnancy:

____

____

Questions or concerns to the doctor:

____

____

Patient Signature: ___________________________________ **Date**: _________________

Staff Use Only:

Age: ___________ G __________ P __________________; LMP: ______________________

Full term: _______ Preterm: _______ Abortions: _______ Miscarriages: _______ Alive: ______

EDC: ___________________ By ☐ LMP ☐ U/S If US: ____________ weeks of Gestation

C/S: _______ SVD: _______ VBAC: _______ Instrumental Deliveries: _______ Complications:

____

Problems List	Medications

Assessment/ Plan:

____

____

____

____

____

____

____

____

____

Physician Signature: ____________________________________ **Date:** _____________

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