Kathleen E. Goodman, MD, LLC
Gynecology
5975 Sunset Drive, Suite 701
South Miami, Florida 33143

COVID-19 QUESTIONNAIRE

Today's Date: ____________________

Patient Name: ______________________________ DOB: __________________________

1. Have you experienced any of the following symptoms in the last 14 days?

• Fever	Yes	No
• Cough	Yes	No
• Shortness of breath or difficulty breathing	Yes	No
• Sore Throat	Yes	No
• Chills or body aches	Yes	No
• Loss of smell or taste	Yes	No
• Headache	Yes	No
• Muscle aches or pain	Yes	No
• Fatigue	Yes	No
• Congestion or runny nose	Yes	No
• Nausea, vomiting or diarrhea	Yes	No

2. Have you been in close contact with someone who has been diagnosed with COVID-19 in the last 14 days? Yes No

3. Have you previously had COVID-19? Yes No
   If yes, when? ______________________________

4. Have you previously been tested for COVID-19? Yes No
   If yes, when? ______________________________
   What was the result? Negative Positive

5. Have you traveled in the last 14 days? Yes No

6. Have you received the COVID-19 vaccine? Yes No
   If yes, when?
   1st Dose ____________________ 2nd Dose ____________________

   Vaccine Name ____

I hereby certify that the above statements are true and correct and understand that a false statement may disqualify me from further services.

____
Patient Signature

Kathleen E. Goodman, MD, LLC

Gynecology

Patient Information

Please print clearly and answer all questions

Date ____________
Fecha

Patient Name ____________
Nombre del Paciente

Home Address ____________
Direccion de Hogar

City ________ State ____ Zip Code ________
Ciudad Estado Codigo Postal

Date of Birth ____________ Age ______
Fecha de Nacimiento Edad

Occupation ____________
Ocupacion

Employer ____________
Empleador

Work Address ____________
Direccion

City ________ State ____ Zip Code ________
Ciudad Estado Codigo Postal

Spouse's Name ____________
Nombre de Esposo(a)

Spouse's Employer ____________
Empleador

Emergency Contact ____________
Contacto de Emergencia

Referred By ____________
Referido Por

Primary Language Spoken ____________
Idioma Preferido

Home Phone ____________
Telefono del Hogar

Work Phone ____________
Telefono del Trabajo

Cell Phone ____________
Cellular

E-Mail ____________

Social Security # ____________
Numero de Seguro Social

Marital Status ____________
Estado Civil

Drivers License # ____________
Numero de Licensia de Conducir

D.O.B. ____________ Spouse's S.S. # ____________
Fecha de Nacimiento Numero del Seguro Social

Spouse's Work Phone ____________
Telefono del Trabajo

Phone Number ____________
Telefono

If you are here for a well woman exam, please check this box ☐
Si esta aqui para un examen rutinario marque esta casetilla ☐

INSURANCE INFORMATION

Name of Primary Insurance ____________
Nombre del Seguro

Address ____________
Direccion

Group Number ____________
Numero de Grupo

Name of Subscriber ____________
Nombre del Asegurado

Subscriber's Employer ____________
Empleador

Phone Number ____________
Telefono

City ________ State ____ Zip Code ________
Ciudad Estado Codigo Postal

Policy or I.D. Number ____________
Numero de Poliza

D.O.B. ____________ Relation to Patient ____________
Fecha de Nacimiento Relacion al Paciente

Work Phone ____________
Telefono

RELEASE OF INFORMATION / ENTREGA DE INFORMACION

I authorize the release of any medical information necessary to process a claim.
Yo autorizo la entrega de cualquier informacion médica necesaria para poder procesar un reclamo.

ASSIGNMENT OF BENEFITS / RENDIMIENTO DE BENEFICIOS

I authorize payment of Medical benefits to myself or the name provider for professional services rendered.
Yo autorizo pago de servicios/beneficios médico a mi persona o al proveedor profesional de los servicios.

Signed: ____________ **Date:** ____________
Firma **asegurado / subscriber or patient** **Fecha**

#101KG 01/04 RN

Kathleen E. Goodman, MD, LLC
Gynecology

Patient History Form

Patient Name ______________________ Date of Birth ____________ Age ______
Occupation ______________________ Ethnic Origin ____________ Sex ______
Marital Status (Please check one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced Primary Language ____________

ALLERGIES	
Medicinal	Other

CURRENT MEDICATIONS	

Last Menstrual Period ____________ Age at first menstrual Period ____________
Are/were your periods usually (Please check one): ☐ Irregular ☐ Regular
Difficulty with Periods? ☐ Yes ☐ No Have Periods Stopped? ☐ Yes ☐ No
Specify: ____________
Number of Pregnancies ______ # Live Births ______ # Abortions ______ # Miscarriages ______ # Stillborn ______
Describe pregnancy complications, if any ____________

Are you currently sexually active (Please check one): ☐ Yes ☐ No Method of Contraception: ____________

MAJOR ILLNESSES	Yes	No	MAJOR ILLNESSES	Yes	No
Asthma	☐	☐	Cancer	☐	☐
Pneumonia	☐	☐	Ulcers	☐	☐
Chronic Lung Disease	☐	☐	Depression/anxiety	☐	☐
Kidney Infections/stones	☐	☐	Anemia/Blood Transfusions	☐	☐
Tuberculosis	☐	☐	Seizures/convulsions/epilepsy	☐	☐
Venereal Disease	☐	☐	Bowel Trouble	☐	☐
Heart Trouble/murmur	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis/ joint pain	☐	☐
High Blood Pressure	☐	☐	Fracture(s)	☐	☐
Stroke	☐	☐	Hepatitis/Yellow jaundice	☐	☐
Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐

INJURIES:

OPERATIONS / HOSPITALIZATIONS			
Surgeris	Date	Hospitalization	Date

#104KG 01/04 RN

Patient Signature ______________________ Physician Signature ______________________
Date: ______________________ Reviewed: __________ __________ __________

PATIENT HISTORY FORM-continued

SOCIAL HISTORY

	Yes	No	Quit		
Tobacco Use	☐	☐	☐	Packs Per Day	Years
Alcohol	☐	☐	☐	Drinks Per Day	Drinks Per Week
Drug Use	☐	☐	☐	Specify	How often
Other Drugs or Medications	☐	☐	☐		
Regular Exercise	☐	☐	☐		
Monthly Self Breast Exams	☐	☐	☐		
Yearly Mammograms	☐	☐	☐		
Colon Cancer Screening	☐	☐	☐		

Please indicate whether immediate relatives (parents, siblings, grandparents, aunts/uncles, cousins, or children) have or died from any of the following:

FAMILY HISTORY

Illness	N/A	Relative	Illness	N/A	Relative
Breast Cancer			High Blood Pressure		
Ovarian Cancer			Heart Disease		
Cervical Cancer			Stroke		
Uterine Cancer			Diabetes		
Colon Cancer			Osteoporosis		
Obesity			Alzheimer's Disease		
Other			Mental Illness		

Review of Systems: Do you have or have you had any problems related to the following systems? Please check Yes or No.

Please explain any Yes answers in the space provided

Constitutional Symptoms	**Yes**	**No**
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Eyes		
Blurred Vision	☐	☐
Double Vision	☐	☐
Vision Changes	☐	☐
Ear/Nose/Throat/Mouth		
Ear Infection	☐	☐
Sore Throat	☐	☐
Sinus Problems	☐	☐
Cardiovascular		
Painful Breathing	☐	☐
Chest Pain	☐	☐
Swelling of Legs	☐	☐
Palpitations of Heart	☐	☐
Respiratory		
Wheezing	☐	☐
Frequent Cough	☐	☐
Shortness of Breath	☐	☐
Hematologic/Lymphatic		
Swollen Glands	☐	☐
Blood Clotting Problems	☐	☐
Frequent Bruising	☐	☐
Endocrine		
Dry Skin	☐	☐
Abnormal Thirst	☐	☐
Hot Fashes	☐	☐

Skin/Breast	**Yes**	**No**
Skin Rash	☐	☐
Pain in Breast	☐	☐
Discharge	☐	☐
Boils	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Neck Pain	☐	☐
Muscle Weakness	☐	☐
Other ______________		
Genitourinary		
Blood in Urine	☐	☐
Painful Urination	☐	☐
Urinary Frequency	☐	☐
Urine Retention	☐	☐
Painful Intercourse	☐	☐
Urinary Incontinence	☐	☐
Other ______________		
Gastrointestinal		
Diarrhea, Frequent	☐	☐
Bloody Stool	☐	☐
Abdominal Pain	☐	☐
Constipation	☐	☐
Neurological		
Tremors	☐	☐
Dizzy Spells	☐	☐
Numbness	☐	☐

Other ______________________________
____