

Please complete each line so that your record can be added to our computer today. Thank you.

Attn: Accounting Department

PATIENT: _____

Last Name

First Name

Initial

Street Address

City

State

Zip Code

ARE YOU EMPLOYED? Yes _____ No _____

HOME PHONE: _____ BUSINESS PHONE: _____

EMPLOYERS NAME: _____

SOCIAL SECURITY NUMBER: _____

BIRTH DATE: _____

Month/Day/Year

Husband's Name: _____

Last Name

First Name

Initial

Husband's Social Security Number: _____ Husband's Employer: _____

IS THE INSURANCE THROUGH YOUR EMPLOYER? Yes _____ No _____

IS THE INSURANCE THROUGH YOUR HUSBAND'S EMPLOYER? Yes _____ No _____

List your employer's insurance company first:

1. _____

Patient's Employer-Insurance Company

ID number/Policy Number

2. _____

Husband's Employer-Insurance Company
(Only if YOU are covered by his plan)

ID number/Policy Number

ARE YOU A MEDICARE PATIENT? Yes _____ No _____ Medicare # _____

Medicare Supplement Insurance? Yes _____ No _____ Contract # _____

FOR OFFICE USE ONLY:

CHART NO. _____ TMP NO. _____

PHYSICIAN _____

NOB _____ NPGYN _____ MF _____

1. Have any members of your family (father, mother, sisters, brothers) had:

| | No | Yes | Which member? |
|---------------------|----|-----|---------------|
| Heart Disease | | | |
| Cancer | | | |
| Tuberculosis | | | |
| Diabetes | | | |
| High Blood Pressure | | | |

2. Is your mother: living _____ age _____ in good health _____
 deceased _____ age at death _____ cause of death _____

3. Is your father: living _____ age _____ in good health _____
 deceased _____ age at death _____ cause of death _____

4. Number of sisters _____ Number of brothers _____

5. What medications are you taking? _____
 Are you allergic to any medications? (Please list ALL) _____

6. Have you had any problems with the following? (If "yes" please give approximate age that you had this problem. If this is a current problem now, please write "current" in the age box.)

| | No | Yes | Age |
|-------------------------|----|-----|-----|
| Head | | | |
| Ears | | | |
| Eyes | | | |
| Nose | | | |
| Throat | | | |
| Thyroid | | | |
| Lungs | | | |
| Heart | | | |
| High Blood Pressure | | | |
| Yellow jaundice | | | |
| Rheumatic heart disease | | | |
| Hernia | | | |

| | No | Yes | Age |
|------------------------|----|-----|-----|
| Kidneys | | | |
| Phlebitis (blood clot) | | | |
| Stomach | | | |
| Intestines (or colon) | | | |
| Hemorrhoids | | | |
| Bladder | | | |
| Cancer | | | |
| Diabetes | | | |
| Pneumonia | | | |
| Painful menstruation | | | |
| Irregular periods | | | |
| Free bleeding | | | |

7. Surgeries:

C-section _____ Date: _____
 Hysterectomy _____ Date: _____
 Tubal ligation _____ Date: _____
 Appendectomy _____ Date: _____
 Gall bladder _____ Date: _____

Other surgeries: _____

8. Total number of pregnancies? _____ miscarriages _____ living children _____ stillborn _____

9. Regarding your menstrual periods: Age at 1st period _____ Usual number of days of flow _____
 Usual number of days between periods _____ Date of last period _____ Was it normal _____

10. Date of last PAP smear _____ Was it normal? _____ Abnormal? _____

11. Have you ever had a mammogram (breast X-ray)? _____ Was it normal? _____ Abnormal? _____
 Date of last mammogram _____

Signature _____

Date _____