[ALL EXISTING RETURNING PATIENTS]

In accordance with the HIPAA law, respecting your privacy, please fill out this short form in advance and hand it to your nurse when you get called back.

Name: _____ DOB: _____

Reason for Visit: _____
Medications: (including outside meds, antibiotics, vitamins and supplements) _____
_____
_____
_____

PLEASE BE AWARE THAT ANY MEDICATION PRESCRIBED TO YOU TODAY MAY NOT BE COVERED BY YOUR INSURANCE AT THE LOWEST CO-PAY. SINCE ALL INSURANCE COMPANY COVERAGE IS DIFFERENT, IF YOU ARE NOT HAPPY WITH YOUR CO-PAY, SEND US YOUR FORMULARY FROM YOUR INSURANCE WEBSITE SO YOUR PHYSICIAN CAN CHOOSE THE CORRECT ONE AT THE FIRST OR SECOND TIER COPAY RANGE FOR YOU.

***DO YOU PREFER LOCAL OR MAIL ORDER FOR YOUR PRESCRIPTIONS? PLEASE LIST YOUR PREFERRED:
Or just list "print" for a handwritten prescription_____***

Drug Allergies:(including Latex)
_____
_____
_____

Reproductive History:
When was the FIRST day of your last menstrual period? ____/____/____
Birth Control Method: (if not listed as a medication)? _____

If Postmenopausal, what age were you when you last menstruated? _____

Social History:
Did you ever use tobacco products? N/A
If yes, do you currently smoke or use tobacco products?

Date of last colonoscopy: _____ normal? N/A
last Bone Density scan:_____ normal? N/A
last Mammogram: _____ normal? N/A
last Pap test: _____ normal? N/A

If Postpartum (and here for a postpartum visit only) please fill out:

	Delivery Date	Gestational Age at Delivery	Weight	Male or Female	Vaginal, Cesarean, VBAC,	Baby's First Name	Physician who delivered	Are you breastfeeding
1.				N/A	N/A		Choose from list	N/A
2				N/A				