NEW PATIENT UNDER 49

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: _____ Height: ____ ft ____ in.

Reason for Visit: _____

Medications: (including outside meds, antibiotics 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 write in "print" for a handwritten prescription_____

Drug Allergies (including Latex) _____
_____

Reproductive History:
How old were you when you got your first period?_____ yrs old.
How often do you get it? (Ex: 28 days) _____
How many days does it last? (Ex. 7 days) _____
When was the FIRST day of your last menstrual period? ____/____/____
Birth Control Method, (if not listed as a medication)? _____

How many times have you been pregnant? (Including miscarriages or terminations)_____
How many were delivered full term? (36-40 weeks)_____
How many were preterm? (20-35 weeks) _____
How many terminations?_____
How many miscarriages? _____
How many were ectopic pregnancies? _____
How many multiple pregnancies?(ex:1 pregnancy with twins)____
How many are living? _____

Please list your pregnancies please include dates of any miscarriages or terminations.

Birthdate	Gestational Age	Male or Female or N/A	Vaginal, Cesarean, VBAC	Miscarriage or Termination
Ex. 02/12/2011	40 weeks	Female	Vaginal	
1		N/A	N/A	N/A
2		N/A	N/A	N/A
3		N/A	N/A	N/A
4		N/A	N/A	N/A
5		N/A	N/A	N/A

Social History:
Did you ever smoke? N/A If yes, do you currently smoke? N/A
Date of last Mammogram _____ normal? N/A
last Pap Test: _____normal? N/A