Premier
Women's Health

NEW PATIENTS *ONLY*, please complete the following information:

Name_____ Date of Birth_____

Responsible party (if minor)_____ Relationship_____

Spouse's Name_____Date of Birth_____Social Security Number_____

Spouse's Employer_____ Spouse's Phone_____

Who referred you to our practice?_____

Insurance Information

Do you have insurance?_____ Please refer to our Patient Financial Policy for instructions pertaining to our financial practices.

MEDICAL HISTORY

What is your reason for coming to the doctor?_____

_____

Please list any medical problems: (e.g. hypertension, diabetes, thyroid disease, etc.)

_____

_____

Please list any surgeries:_____

_____

Please list any allergies to medications:_____

_____

FAMILY HISTORY: Please check if family members have had any of the following:

	Mother	Father	Grandparent	Siblings	Aunt/Uncle	Children
Breast cancer						
Ovarian cancer						
Uterine cancer						
Colon cancer						
Other cancer						
Hypertension						
Heart Disease						
Clots/embolism						
Diabetes						

OBSTETRICAL HISTORY

Number of pregnancies:_____

Number of live births:_____

Number of vaginal deliveries:_____

Number of C-sections:_____

Number of miscarriages:_____

Number of other pregnancies:_____

GYNECOLOGICAL HISTORY

Date of last menstrual period: _____

Age at first menstrual period: _____

Menstrual flow occurs every: _____days

Menstrual flow lasts: _____days

Date of last pap test: _____

Birth control method:_____