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?_______________________________

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

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Please list any surgeries:_______________________________

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Please list any allergies to medications:_______________________________

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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:_______________