Your Doctor

WHO ARE YOU SEEING TODAY?

PLEASE COMPLETE FRONT & BACK

[ ] DR. LABARRE [ ] DR. BELLMANN [ ] DR. CASSIERE

Patient Information

Date _____/_____/_____ **Appointment Time** _____ **Arrival Time** _____

NAME _____ NEW PATIENT [ ] YES [ ] NO
First Middle Last

AGE _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____
mm/dd/yyyy

PRIMARY CARE PHYSICIAN _____ INSURANCE PLAN _____

Chief complaint

Why are you here today? **[ ] Well Woman Exam (Annual Exam) [ ] Problem Visit [ ] Lab [ ] Ultrasound**

What is your problem? _____

Date of Last Menstrual period _____ **Last Pap Smear** _____ **Last Mammogram**_____

Contact Infromation

Check Preferred Contact Number

[ ] MOBILE PHONE _____

[ ] HOME PHONE _____

[ ] WORK PHONE _____

EMAIL _____

May we use email for contacting you? [ ] Yes [ ] No

ADDRESS _____
Street

_____
City state zip

Demographics

Check one

RACE: [ ] Asian [ ] Black [ ] Hispanic [ ] White [ ] Other _____

Diagnosis

Please Circle All That apply

Hypertension Diabetes Breast Cancer Other Cancer Menopause Fibroids Migraines

Hypothyroid Hyperthyroid Heart Disease Pulmonary Disease Gastric Reflux Stomach Ulcers

Liver Disease Colon Disease Kidney Disease Urinary Incontinence Arthritis Skin Disease Lupus

Other Not listed _____

SMOKING STATUS : [ ] NO [ ] YES Packs Per Day _____

Past Medical / Surgical History

Write in numbers below

Number of Pregnancies _____Premature Deliveries _____Living Children_____

Miscarriages_____ Pregnancy Terminations _____ Vaginal Births_____ Cesarean _____

Please Circle All Previous Surgeries That Apply: Cesarean Section Tubal Ligation Hysterectomy ✻

Ovary Removal Bladder Appendectomy Gall Bladder Laparoscopy Breast

Other Not listed _____

Family History of Cancer and Disease

Please Circle All That apply and list Family Member

Breast _____ Ovary _____ Uterine _____Intestinal _____ Pancreas _____

Diabetes_____Hypertension_____Heart Disease _____

Other: _____

Allergies

✻

Do You Have any Allergies: [ ] NO [ ] YES

LIST ALL ALLERGIES: _____

_____

Medications

INCLUDING BIRTH CONTROL

LIST ALL MEDICINES: _____

Name Strength How Often Taken Per Day

_____

Name Strength How Often Taken Per Day

_____

Name Strength How Often Taken Per Day

_____

Name Strength How Often Taken Per Day

_____

Name Strength How Often Taken Per Day

_____

Name Strength How Often Taken Per Day

CONTINUE ON SEPARATE SHEET IF NECESSARY – ASK RECEPTIONISTIST IF NEEDED

Your preferred pharmacy

✻

Name of Pharmacy _____

Pharmacy Location _____ Zip Code _____

THIS IS CONFIDENTIAL PATIENT INFORMATION THAT IS USED FOR YOUR DOCTORS FOR WOMEN ELECTRONIC MEDICAL RECORD AND WILL NOT BE SHARED WITH ANY THIRD PARTY – THANK YOU