MR#: ___________

Division 22
Drs. Band, Sine, Resta, Lizardo,
Shrout, Lin, Footer,
Wagar,Vignali, Lefkof NP

Current Patient Questionnaire

Today's Date: ______________________________ Reason for Visit: ________________________________

Patient Name:______________________________ Date of Birth: ___/___/____ Phone#_______________

Religion: ________________________ Place of Birth: __________________________________

Currently Pregnant: Yes No If yes, name of father: __________________________________

Pharmacy________________________________ Phone: ________________________________

Address: ____

Primary Care Provider: ______________________ IUD Name___________________Date Inserted_____/_____/____

Date of Last Menstrual Period: ______/______/_______ H PV Vaccine 1st:_________ 2nd:_________ 3rd:________

Current Medications/Birth Control

Drug	Dosage

Allergies

Type of Allergy	Reaction

Past Obstetrical History Full Term: ___Premature: ____Abortion: _____ Miscarriages: ___Living Children: _________

Have you had any changes to your medical history since your last visit with us? Yes_____ No _____

If yes, please explain: ____

Have you had any surgeries or hospitalizations or any new medical diagnoses since your last visit with us? Yes _____ No _____

If yes, please explain: ____

Have there been any changes in your family history since your last visit with us? Yes ____ No ____

If yes, please explain: ____

Social History

	Caffeine	**Tobacco**	**Alcohol**	**Recreational Drugs**
Current				
Type:				
Amount:				
Year Stopped:				

Do you feel safe in your current environment? Yes No

Are you experiencing and problems with urinary incontinence? Yes No

Test/Procedure	**Pap**	**Mammogram**	**Bone Density**	**Colonoscopy**
Year				
Result				

If someone referred you to our group, please let us know so that we may thank them: ___________________________

____

Printed Patient Name

____

Signature of Patient or guardian of minor