Wendy Giles, MD

New Patient Forms

Date: _____

Name: _____ Birthdate: _____

Address: _____ City_____

State: _____ Zip Code: _____ Home Phone: _____

Social Security #: _____ Cell or Alt. Phone: _____

Emergency Contact: _____Contact Number: _____Relation:_____

Patient Employer: _____ Work Phone: _____

Person Who Is Insurance Policy Holder Name: _____ Self ___ I Am Self Pay ____

Policy Holder Birthdate: _____ Relation to Policy Holder: _____

E-Mail address:_____

Pharmacy Name: _____ Pharmacy Phone #: _____

Previous Pregnancies

Please give all information in regard to your previous pregnancies by filling in the spaces below.

Year of Birth/Boy/Girl	Length of Pregnancy	Birth weight of infant	Normal/C-Section	Complications	Total weight gain

Please Answer Each Question: Check Yes or No.

Have You Ever Had?

Yes	No		Date	Yes	No		Date
_	_	Anemia	_____	_	_	High Blood Pressure	_____
_	_	Diabetes	_____	_	_	Arthritis	_____
_	_	Thyroid Disease	_____	_	_	Tumor of any kind	_____
_	_	Herpes	_____	_	_	Gall bladder trouble	_____
_	_	Chlamydia	_____	_	_	Hepatitis	_____
_	_	HPV	_____	_	_	Hernia	_____
_	_	Convulsions	_____	_	_	Hemorrhoids	_____
_	_	Serious head Injury	_____	_	_	Kidney stones/disease	_____
_	_	Epilepsy	_____	_	_	HIV (Aids)	_____
_	_	Hearing difficulty	_____	_	_	Bladder Trouble	_____
_	_	Heart trouble	_____	_	_	Varicose veins	_____
_	_	Lung Problems	_____	_	_	Depression	_____
_	_	Headaches	_____	_	_	Appendicitis	_____
_	_	Bipolar	_____	_	_	Skin Disease	_____

Other: _____

_____