**General Information (please print)**

Name: ______________________________ DOB ______________ Sex: __M __F

Social sec # ____________________ Marital status: Single___ Married___ Divorced ___Widowed ___

Primary address ____________________________________________

City ______________________________ State __________ Zip ______________

Home phone _______________Work phone ______________ Cell phone ______________

E-mail____________________________________________________________

Emergency Contact _________________ Relationship ________ Phone ______________

Pharmacy name _______________________ Phone ____________ Fax ____________

Employer: ____________________________ Occupation ______________________

Mothers Maiden name: ______________

(check please)

RACE: ____ White _____ Black or African American _____ Asian ______ American Indian _____ other

ETHNICITY: ______ Hispanic or Latino _______ Not Hispanic or Latino

**Doctor Information**

Referring Physician ____________________________ Specialty ________________

Primary Care Physician __________________________ Phone ________________

**Our office does NOT file insurance. Payment for office services are due on the day of the visit. Payment maybe made by check, cash, and credit card/debit. We collect your insurance information only for referral information.**

Insurance name __________________________ Subscriber's name ________________

Insurance ID#: _______________________________________________________

Social Sec # __________________ DOB __________ Relationship to insured ____________

I hereby state that all the information provided is true and completed to the best of my knowledge. I understand that I am solely responsible for my total bill.

______________________________ ______________________

Patients Signature Date

**NAME:** ________________________________________ **DOB:** ____________________________

- **ALLERGIES**

Note any of the following medications or substances that cause an allergic reaction:

_____ I am Not allergic to any medications or substances.

Put Check in Y/N box if allergic and please put a S for Severe Or M for Mild to describe your allergic reaction

| Y/N | | S | M | Y/N | | S | M | Y/N | | S / M |
|---|---|---|---|---|---|---|---|---|---|---|
| | Penicillin | | | | Ibuprofen | | | | Codeine | |
| | Sulfa | | | | Shellfish | | | | Demerol | |
| | Erythromycin | | | | Iodine | | | | Morphine | |
| | Tetracycline | | | | Peanuts | | | | Other Foods | |

- **MEDICATION**

If you are taking medication regularly of any kind, please list below:

____ I am Not currently taking any medication.

| Name of Medication | Dose (mg) | Times per Day | Prescribing Doctor | Reason for use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Supplements

| Supplements/Over the counter medication | Dose & Frequency | Approx. Start Date | Reason for use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Screening/Tests

| Test | Last Date Done | Ordering Physician/address |
|---|---|---|
| Blood Work | | |
| PAP smear/HPV | | |
| Mammogram | | |
| Ultrasound | | |
| Bone Densitometry | | |
| Colonoscopy | | |
| Cardiac Test(EKG/Echo/stress) | | |

**NAME: _________________________________________ DOB: _________________________**

- **MEDICAL ILLNESSES**

Indicate if you or an immediate family member have been diagnosed in the past by a physician with any of the following medical illnesses. That would include birth parents, grandparents, siblings and natural children.
List any pertinent details in the space below:
_____ I have had NONE of the medical illnesses listed below to my knowledge.

| Self | Fam | | | Self | Fam | |
|---|---|---|---|---|---|---|
| | | Breast Cancer | | | | Neuromuscular syndrome |
| | | Heart Disease | | | | High blood pressure |
| | | TIA or Stroke | | | | Thyroid Disease |
| | | Liver Disease | | | | Lupus/rheumatoid |
| | | Diabetes | | | | Neuromuscular syndrome |
| | | Pulmonary embolus | | | | DVT(deep vein thrombosis) |

List any other medical problems or on going illnesses not specified above:

- **SURGICAL HISTORY**

Indicate if you have had one or more of the following operations or procedures:
_____ I have NEVER had a surgery or operation to the best of my knowledge.

| | |
|---|---|
| | Hysterectomy w/both ovaries removed |
| | Tubes tied (tubal ligation) |
| | Laparoscopy |
| | Bladder Repair |
| | Thyroid Surgery |
| | Gallbladder removed |
| | Breast biopsy |
| | Mastectomy |

List any other surgical procedure or complication that is not specified above:

**Name:** ___________________________________________ **DOB:** __________________________________

**Please note below if you are experiencing any of the following symptoms on today's visit and which you have not addressed with another physician:**

| YES | NO | SYMPTOM | YES | NO | SYMPTOM |
|---|---|---|---|---|---|
| | | Hot Flashes | | | Insomnia |
| | | >10lb weight loss | | | Fluid Retention |
| | | Breast tenderness or mass | | | Lower back pain |
| | | Heart "flutters" | | | Headache |
| | | Depression/anxiety | | | Excessive fatigue |
| | | Painful intercourse | | | Lower back pain |

**Smoking history**

Smoker ____ How many packs daily ____
Never Smoked ____
Former Smoker ____ How many packs did you smoke daily ____

Do you drink alcohol? ______
How many per day? ______
How many per week? ______

Do you exercise regularly? _______

Have you ever been treated for alcohol or drug addiction? _______

Do you have a healthy diet? ________

Name: ____________________________________________ DOB: _________________________________

- **GYNECOLOGICAL HISTORY**

- When was your last Menstrual Period? ________________________________________
- Was it Normal? _______________________________________________________
- How many days did you bleed? _____________________________________________
- Cramps? ____________________________________________________________

| | YEARS | What was the approximate age when your menstrual period began |
|---|---|---|
| Yes | No | Have you ever had an abnormal Pap smear? |
| | Laser? | If yes, did you have Laser, freezing, or other treatment performed? Or was it simply repeated? |
| | Freezing? | _______ Other? _________ Repeated? |
| Yes | No | Have you ever been sexually abused, raped or otherwise molested? |
| Yes | No | Have you had difficulties with abnormal dark hair growths on the face, chest, or abdomen? |
| Yes | No | Have you ever had milky discharge from the breasts and not been pregnant or immediately postpartum? |

Have you been diagnosed with any of the following Gynecological disease or infections in the past?

| | Endometriosis | | "PID" | | Pelvic inflammatory Disease |
|---|---|---|---|---|---|
| | Fibroids | | Adhesions | | Infertility |
| | Chlamydia | | Herpes simplex | | Trichomonas |
| | Syphilis | | Genital "warts" | | |
| | Fibrocystic disease | | Gonorrhea | | |

- **REPRODUCTIVE HISTORY**

| | Total number of pregnancies |
|---|---|
| | Total number of times that you have been in labor or had a C-section |
| | Total number of miscarriages |
| | Total number of living children |

Indicate if you have had any of the following complications of pregnancy:
_____ High Blood Pressure
_____ Diabetes
_____ OTHER
(specify)______________________________________________________________

**CYNTHIA NEAL FRAZIER M.D. IS DEDICATED TO PROVIDING YOU WITH FAST RELIABLE INFORMATION CONCERNING YOUR CARE. IN MANY CASES, WE MAY NOT BE ABLE TO TALK DIRECTLY TO YOU BECAUSE YOU MAY BE AWAY FROM YOUR TELEPHONE. ONE CONVENIENT ALTERNATIVE IS TO LEAVE A MESSAGE FOR YOU TO CHECK. EMAIL IS A HELPFUL MEANS OF COMMUNICATION, AS WE CAN OFTEN SEND YOU RELATED PUBLICATIONS OF OTHER SORUCEFUL INFORMATION TO YOU. PLEASE INDICATE YOUR WISHES BELOW BY SIMPLY INITIALING ONE OR MORE OF THE FOLLOWING CHOICES.**

I authorize the staff of ***anti-aging by the sea…*****A CLINIC FOR WELLNESS** to leave or transmit important and potentially confidential information to one or more of the following:

________Voicemail on cell phone (Dr. Frazier's choice)
________ Answering Machine on home telephone numbers listed on page one
________ Voicemail on the work number listed on page one, only if the voice mail message specifically mentions your name.
________ E-mail address listed on page one.

**PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT**

(ONLY COMPLETE IF YOU ARE LESS THAN 18 YEARS OF AGE AND NOT MARRIED OR IF YOU ARE LESS THAT 25 YEARS OF AGE AND ENROLLED IN SCHOOL FULL TIME)

**NAME:** ________________________________________________
**RELATIONSHIP TO PATIENT:** ______________________________
**ADDRESS:** _____________________________________________
_____________________________________________
**CELL PHONE:** __________________________________________
**HOME PHONE:** _________________________________________
**WORK PHONE:** _________________________________________
**OTHER(SPECIFY):** ______________________________________
**SOCIAL SECURITY NUMBER:** ____________________________
**DATE OF BIRTH:** _______________________________________

Signature: _____________________________________________________________

Date: ______________________________________