Demographics

First Name:_____ MI:____ Last Name:_____

SS#:_____ Date of Birth_____ Age:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____Cell Phone_____Work Phone_____

Employer:_____ Occupation:_____

Best Number to reach you: ____Home ____Cell ____Work

Patient Email:_____

Marital Status:

____ Single ____Married ____Divorced ____Widowed ____Separated

Emergency Information:

Emergency Contact Name: _____

Relationship:_____ Phone Number:_____

Emergency Contact Name: _____

Relationship:_____ Phone Number:_____

Primary Care Physician

Name:_____

Phone:_____ Fax:_____

Pharmacy Information:

Name:_____ Phone number: _____

Address:_____ Store #:_____

Signature:_____ **Date:**_____

WOMEN'S
HEALTH SPECIALISTS
OF CENTRAL FLORIDA

Reason for today's visit: (Circle One)

Annual Exam Pelvic Pain Post Menopausal Bleeding Abnormal Pap

Abnormal Bleeding Abnormal Imaging Birth Control Consult about Surgery

Other:_____

ALLERGIES:

_____

OB History:

Total number of pregnancies:____ Total Living:____ Miscarriages:____

Abortions____ Multiples____

Number of Vaginal Deliveries____ Number of C-Sections____

GYN History:

Last Menstrual Cycle:_____ Sexually Active: Yes No Total:_____

Lifetime Partners:_____

Age at Coitarche:____ Age at Menarche:____ HPV: Positive Negative

HPV Vaccination: Yes No

Birth Control Method:(circle one)

Tubal Ligation Condoms Oral Contraceptives Depo-Provera

IUD Nexplanon/Implanon Nuva Ring Other:_____

Last Pap:_____ Abnormal: Yes No If Yes, Describe:

_____

Last Mammo:_____ Abnormal: Yes No If Yes, Describe:

_____

Last Dexa Scan:_____ Abnormal: Yes No If Yes, Describe:

_____

Last Pelvic Ultrasound:_____ Abnormal: Yes No If Yes, Describe:

_____

History of STD: Yes No If Yes, Describe:

_____

History of Endometriosis: Yes No

History of Fibroids: Yes No

History of Cyst: Yes No

History of Infertility: Yes No

History of PCOS: Yes No

History of Cervical Dysplasia: Yes No

History of Ovarian Problems: Yes No

WOMEN'S
HEALTH SPECIALISTS
OF CENTRAL FLORIDA

Surgical History:

List Surgeries	Year
1.	
2.	
3.	
4.	
5.	

Medical Conditions:

1.	
2.	
3.	
4.	
5.	

Medication List: (please include dosage)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Family History (please circle all that apply)

Breast Cancer Ovarian Cancer Uterine Cancer

Cervical Cancer Colon Cancer Melanoma

Diabetes Stroke Epilepsy Anemia Asthma

High Blood Pressure High Cholesterol

Migraines Hypo/Hyperthyroidism

Social History:

Yes No	Smoking
Yes No	Drinking
Yes No	Illegal Drugs
Yes No	Exercise
Yes No	Ever been Sexually Abused

WOMEN'S
HEALTH SPECIALISTS
OF CENTRAL FLORIDA

Acknowledgment of receipt of Notice of Privacy Practice.

I have received a copy of this office's Notice of Privacy Practice.

_____

Please Print Name

_____

Signature Date Of Birth

_____

Date

Please list the names of anyone who the office staff may release information to on your behalf. If they are not in this list no information will be released regarding your care or condition.

Name	Relation to Patient
_____	_____
_____	_____
_____	_____

_____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to accept Notice.
_____ Individual refused to sign Acknowledgement
_____ Individual was unable to sign.
_____ An emergency situation prevented us from obtaining acknowledgment.
_____ Other:

_____

_____

Employee Signature Date