Lagrange Women's Health

Please help us update your chart by filling out the following…..

Please make sure we have your most current insurance card on file. Thank you!!!

Date: _____

Name: _____ Date of Birth: _____

SS#: _____ Marital Status_____ Age: _____ Race: _____

Home #: _____ Mobile #: _____Work#_____

Mailing Address: _____

City/State: _____

Patient's Employer: _____

Insurance Policy Holder's Employer: _____

Insurance Name: _____ Policy ID: _____

Policy Holder's Name: _____ DOB: _____ SS#:_____

Emergency Contact Name_____ Emerg Cont #_____

Patient's Email Address: _____

Please list your preferred pharmacy and location: _____

Reason for Today's Visit:

_____ Routine Physical Exam

_____ Problem Visit (briefly describe): _____

Medical History

Please list any <u>personal</u> medical problems (ex. High blood pressure, high cholesterol, diabetes, etc.)

_____

_____

Please list any allergies to medications, if any, and what type of reaction:

_____

Please indicate if you have a family history of any of the following conditions and please list the relative affected (ex. Mother, father, maternal grandfather, paternal grandmother, etc.)

Breast Cancer: _____ Diabetes:_____

Ovarian Cancer: _____ Stroke: _____

Colon Cancer: _____ High Cholesterol: _____

High Blood Pressure: _____ Osteoporosis:_____

Heart Disease: _____ Blood Clots: _____

Social History

Do you smoke cigarettes? _____ How many per day? _____

Have you every smoked? _____ When did you quit? _____

Do you drink alcohol? _____ How many drinks per day? _____ week? _____

Do you use street drugs? _____

Do you consume caffeine? _____ Do you eat a healthy diet? _____

Do you get regular exercise? _____ Do you use your seatbelt? _____

Have you been hit, slapped, kicked, or otherwise physically abused in the last year? _____

Please list all medications you are currently taking (please include how often and the dosage)

_____

_____

Number of pregnancies: _____ Number of living children: _____

Number of full term pregnancies: _____ Number of miscarriages: _____

Number of preterm pregnancies: _____ Number of abortions: _____

Number of ectopic/tubal pregnancies: _____

Please list all previous surgeries: _____

_____

Please list the dates for the following:

Last pap smear _____ Last mammogram: _____

Last colonoscopy: _____ Last bone density scan: _____

Last flu vaccination: _____ Last menstrual period: _____

Primary Care Physician: _____ Referred by? _____