PATIENT NAME: ____

ADDRESS:____

CITY: ________________________________ STATE: ________ ZIP: ____________________

TELEPHONE- HOME: (_____)__________________ WORK:(_____)______________________

EMAIL ADDRESS:____

CHECK ONE: F/T STUDENT______ P/T STUDENT______ EMPLOYED______ UNEMPLOYED______

CHECK ONE: SINGLE_______ MARRIED______ OTHER_______

PATIENT

EMPLOYER/SCHOOL: ____

EMPLOYER/SCHOOL ADDRESS: ____

SS#: ______________________________________

DATE OF BIRTH: _____________________________

SPOUSE / GUARDIAN

NAME:____

TELEPHONE: WORK (____) ___________________________________

SS#: ____

DATE OF BIRTH: ______________________________

EMERGENCY CONTACT (NAME & NO.):

____

Nearest relative not living at the same address:

NAME: ____RELATIONSHIP: ________________

ADDRESS____ PHONE NO.: _______________

PATIENT NAME_____________________
AGE________________

PRIMARY INSURANCE INFORMATION

INSURANCE CO.: ____

CLAIMS ADDRESS: ____

CITY, STATE ZIP: ____

GROUP NO: ____

POLICY/ID#: ____

SECONDARY INSURANCE INFORMATION

INSURANCE CO.: ____

CLAIMS ADDRESS: ____

CITY, STATE ZIP: ____

GROUP NO.: ____

POLICY/ID#: ____

Assignment of Insurance Benefits and Authorization to release Information

I authorize payment of medical benefits to Elite Women's Care Center, PA for any and all services not paid in full at
the time services are rendered.
I authorize Elite Women's Care Center, PA to release any medical information as necessary for the completion of
my insurance claims to any insurance carrier, health, or hospital plan.

PATIENT____ DATE_________________

PATIENT'S LEGAL GUARDIAN____________________________________ DATE______________

PATIENT NAME_____________________
AGE________________

PAST HISTORY: **CIRCLE ALL THAT APPLY**

Arthritis
Asthma
Breast Tumor
Diabetes
Heart Attack
Heart Murmur
Hepatitis
High Blood Pressure
High Cholesterol
Intestinal Bleeding

Kidney Infection
Kidney Stone
Migraine Headaches
Mitral Valve Prolapse
Neurological Disease
Osteoporosis
Paralysis
Pneumonia
Rheumatic
Thromboembolic Events

Thyroid Problems
Other Heart Disease______________
Other Kidney Disease______________
Infectious Diseases(TB, HIV, etc..)____________
Other Lung Disease______________
Other Genetic/Inherited Disease_______________

Number of:

___Pregnancies
___Miscarriages
___Living Children
___Deliveries
___Abortions

Please list pregnancies in chronological order:

MM/DD/YY	SEX	WT	TYPE OF DELIVERY	ANESTESIA	COMPLICATIONS

PATIENT NAME______________________
AGE_________________

List all previous surgeries (Type and Approximate Date)

Will you permit a blood transfusion for medical reasons?
____
Date of last menstrual cycle: _____________________ Are your cycles regular?
____
Describe any problems with your cycles: ________________________
Current type of birth control____________________________ Do you want to change birth control? Y N
What birth control options are you interested in?
____
Did your mother take DES or other hormones while pregnant with you?
____

Regarding your female organs: **Circle all that apply**

Abnormal Bleeding	Pelvic Infections
Chlamydia/Gonorrhea/Syphilis/Herpes	Tubal (Ectopic) Pregnancy
Genital Warts	Tumor of the Uterus or Ovaries

Have you ever had an abnormal Pap Smear? ______________ Treatment? _________________
Are you sexually active? ________________ Any concerns or discomfort? __________________

List all currently used Medications (Please include herbal medications and compounded drugs)
____
List allergies to
medications____

Do you drink alcohol?______If yes, number of drinks, beers, glasses of wine per week_________
Do you smoke?______________If yes, number of packs per day/week ____________________
Are you using any other drugs? __________________ Type? _____________________________

PATIENT NAME_____________________
AGE________________

Family History: Is there a member of your family with a history of:

_____Cancer Who/Type?______________________________

_____Congenital (Inherited) Disease Who?____________________________________

_____Diabetes Who?____________________________________

_____Heart Disease Who?____________________________________

_____High Blood Pressure Who?____________________________________

_____High Cholesterol Who?____________________________________

_____Kidney Disease Who?____________________________________

_____Mental Retardation Who?____________________________________

_____Osteoporosis Who?____________________________________

_____Twins Who?____________________________________

Date of last Pap Smear___________________ Results_________________________
Date of last Mammogram_________________Results__________________________
Date of last Bone Density_________________ Results__________________________
Date of last Colonoscopy__________________Results__________________________

Reason for today's visit
____
____

What changes have there been in your life recently?
____
____

Pharmacy Name and Phone
Number____

Do you need 1 month or 90 day prescriptions? _________________________________

How did you hear about us? ___ Katy Magazine ___ Absolutely Katy ___ Prior Patient
___ Email ___ Friend/Relative ___ Yellow Pages ___ Primary Care ___ Consultant

PATIENT NAME_____________________
AGE________________