

Finger Lakes Women's Health, PLLC

OBSTETRICS AND GYNECOLOGY

90 OFFICE PARK WAY
PITTSFORD, NY 14534
(585) 586-3640

4 COULTER ROAD
CLIFTON SPRINGS, NY 14432
(315) 462-5499

****Please Complete BOTH SIDES and return by mail prior to you appointment****
****Failure to return prior to your appointment may severely delay your appointment time.****

NAME: _____ BIRTH DATE: ____/____/____

ADDRESS: _____

HOME:(____) _____ CELL:(____) _____ WORK:(____) _____

INSURANCE CO: _____ Subscriber ID #: _____

MARITAL STATUS: Married Single Widow Divorced Other: _____

PHARMACY/Location/Phone: _____

Primary Care Physician (PCP): _____ PCP PHONE# _____

How did you learn of our office? (CIRCLE ONE)
YELLOW PAGES NEWSPAPER INTERNET FRIEND OTHER _____

Who is your FLWH preferred Physician? _____

Have you ever seen one of our clinicians at another location? (Who/Where) _____

Do you have or have you ever been diagnosed with any of the following: (circle problem)

<u>Respiratory:</u>	<u>Date of Onset</u>	<u>GYN:</u>	<u>Date of Onset</u>
ASTHMA		ABNORMAL PAP SMEAR	
LUNG PROBLEMS (describe)		ENDOMETRIOSIS	
<u>Heart:</u>		INFERTILITY	
HIGH BLOOD PRESSURE		OVARIAN CYSTS / PCOS	
HEART DISEASE/PROBLEMS (describe)		FIBROIDS	
<u>Nervous System:</u>		IRREGULAR / NO MENSTRUAL CYCLES	
STROKE		<u>Musculoskeletal:</u>	
MIGRAINES		ARTHRITIS/JOINT or BACK PAIN	
SEIZURES/CONVULSIONS/EPILEPSY		OSTEOPOROSIS / OSTEOPENIA	
<u>Endocrine:</u>		<u>CANCER:</u> (please describe)	
THYROID DISEASE (describe)			
DIABETES (list type)		<u>Psychology:</u>	
<u>Hematology/Oncology:</u>		SCHIZOPHRENIA	
ANEMIA/BLOOD TRANSFUSIONS		BIPOLAR DISORDER	
<u>Gastrointestinal:</u>		DEPRESSION	
GERD		ANXIETY	
BOWEL TROUBLE (describe)		<u>OTHER</u> (please describe)	
HEPATITIS /JAUNDICE/LIVER DISEASE			

SOCIAL HISTORY:

SMOKING: Yes/No Packs per day: _____ #YEARS: _____

ALCOHOL: Yes/No Drinks per day: _____

DRUG USE: Yes/No (type) _____ **SEAT BELT USE: Yes/No**

GYN IMMUNIZATION:

HPV vaccine Yes/No _____

(dates): _____

MEDICATION ALLERGIES: _____ / **Reaction to Medication** _____

/_____

/_____

/_____

/_____

CURRENT MEDICATIONS:(or attach separate sheet) / **Dosage** / **Why are you on this med?**

/_____

/_____

/_____

/_____

/_____

/_____

OPERATIONS or HOSPITALIZATIONS: _____ **Date / Location / Surgeon** _____

FAMILY HISTORY: (Relation) _____

LUNG PROBLEMS (describe)

STROKE

HIGH BLOOD PRESSURE

THYROID

HEART PROBLEMS (describe)

DIABETES

OTHER:

CANCER (describe):

When was your last: (include result) _____

Pap Smear:

Bone Mineral Density:

Mammogram:

Colonoscopy:

Eye exam:

Dental exam:

Annual labs:

REPRODUCTIVE HISTORY:

Total pregnancies:

Full term:

Premature:

Miscarriages:

Other: _____

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