

Preferred Hospital

A Woman's View

Family Doctor _____

FRMC CVMC

Patient Information Form

Today's Date: _____ Home Phone: _____ Work Phone/Ext: _____

Name: _____ DOB: _____ Age: _____

Allergies: _____

Last Menstrual Period: _____ Birth Control: _____ Urinary Problems? Yes No

No. of Pregnancies: _____ No. of Children: _____ No. of Miscarriages or Abortions: _____

<u>Medication</u>	<u>Dosage</u>	<u>Reason for Medication</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoker Yes No If Yes, how much? _____ Alcohol Yes No Occasionally

Self Breast Exam Monthly Occasionally Never

Surgeries: _____

Reason for Visit: _____

Do not fill in information below the dashed line. Thank you.

History: _____

<u>Vitals</u>	<u>Exam</u>	<u>Impression</u>	<u>Plan</u>
BP _____	Full Exam	_____	_____
_____	Normal Abnormal	_____	_____
Temp _____	Pelvic Exam	_____	_____
Ht _____	Normal Abnormal	_____	_____
Wt _____	Breast Exam	_____	_____
Last PAP _____	Normal Abnormal	_____	_____
Last Mam _____	No Exam	_____	_____

Return Appointment: _____