SPARTANBURG & PELHAM OB-GYN, P.A.

Account # _____

Name: _____ Dr. _____ Date: _____

Age: _____ Family Physician: _____

Emergency Contact: _____ Phone Number: _____

Last Menstrual Period: _____ Irregular Bleeding?: _____ Having Pain?: _____

If having pain, please describe: _____

Are you a smoker? _____

**Are there any problems that you need to discuss with your doctor?** **Yes** **No**

Please Explain: _____

Are you having urinary leakage?: _____ Burning? _____ Uninary Frequency? _____

Do you have asthma?_____ Under the care of:_____

List any Drug Allergies: _____

List any CURRENT Surgeries: _____

List all Medications that you are taking: _____

*****Starting at age 20:**

Last Cholesterol (every 5 yrs) _____ Fasting Glucose (every 3 yrs) _____

Tetanus Inj (every 10 yrs) _____ Thyroid Test (every 5 yrs) _____

*****Starting at age 50:** _____

Colonoscopy (every 10 yrs) _____ Bone Density (every 2 yrs) _____

Influenza Vaccine _____ Pneumococcal Vaccine _____

Refer to Family Physician _____ Refer to Family Physician _____

**Date of your last Mammogram:** _____

**For office use only**

Weight: _____ HT: _____ BP: _____ Urine: _____ HGB: _____

If patient is a smoker, was she counseled? (filled in by Dr.) Yes _____ No _____

**Gravida** _____ **Para**_____

**Notes** **Initials** _____

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rev 7/1/2009