

Vagisha Sharma, MD PA

Your Name _____

Today's Date / /

Address _____

Date of Birth / / Age ____

City _____ State ____ Zip _____

Home Phone () -

Occupation _____

Work Phone () -

Social Security Number - -

Cell Phone () -

In Case of Emergency Notify _____ ()

Employer _____

I hereby authorize and consent to Dr. Sharma and associates to examine me medically and/ or perform a Pap Smear and/or issue any other treatment she may in her judgement determine advisable for my medical well being. I authorize Dr. Sharma and her associate physicians to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physicians, or to assist with, aid in, or facilitate the collection of data for the purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, managed care organizations, IPA's, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary care physician or any other that is directly or indirectly responsible for my medical care or the payment thereof.

Signature: _____ **Date** / / _____

How did you find out about us? _____

Insurance Holder: Self Spouse Parent Other _____

Insured's Name (If Spouse or Parent) _____ **Insured's D.O.B.** / /

Insured's Social Security Number - - **Employer** _____

Insurance Company _____ Group # _____ Phone# _____

Insurance Co. Address _____ City _____ State ____ Zip _____

Reason for Today's Visit: _____

Do you have any specific questions or problems that you would like to discuss today?

No Yes _____

When was your Last Menstrual Period? _____ **When was your last Pap Smear?** _____

Have you seen any other doctors recently? No Yes *Whom, Why?* _____

Are you currently taking any medication? No Yes *List* _____

Do you take any vitamins or herbal supplements? No Yes *List* _____

Do you have any allergies or sensitivities to medication? No Yes *List* _____

Do you do examine your breasts monthly? No Yes *How often?* _____

Have you ever had a mammogram? No Yes *Results* _____

Are you taking calcium to prevent osteoporosis? No Yes _____

Have you ever had a cholesterol test? No Yes *Results* _____

Do you want testing for Sexually Transmitted Diseases (STD's)? No Yes *Explain* _____

Do you have questions about sex or STD's? No Yes _____

Do you have pain with sex? No Yes *Explain* _____

Do you have any problems at home? No Yes *Explain* _____

Has there been any change in your relationship with your partner? No Yes *Explain* _____

Have you ever been tested for H.I.V.? No Yes *Results* _____

Do you smoke? No Yes *How much?* _____

Do you drink alcohol? No Yes *How much / often?* _____

Do you use any street or recreational drugs? No Yes *What type / often?* _____

Do you now, or have you ever, had any of the following? [v]

- No Yes Asthma
- No Yes Anemia
- No Yes Bleeding Tendencies
- No Yes Blood Clots in Leg (Phlebitis)
- No Yes Blood Transfusion
- No Yes Breast Lump or Discharge
- No Yes Bulimia or Anorexia
- No Yes Cancer _____
- No Yes Drug /Alcohol Dependency or Abuse
- No Yes Diabetes
- No Yes Depression
- No Yes Gallbladder Disease
- No Yes Heart Disease or Murmur
- No Yes High Blood Pressure
- No Yes Jaundice or Hepatitis
- No Yes Fractures, List _____
- No Yes Hospitalizations, List _____
- No Yes Kidney Problems
- No Yes Liver Disease or Tumor
- No Yes Lung Disease
- No Yes Migraines
- No Yes Mononucleosis
- No Yes Neurologic Disease or Seizures
- No Yes Neuromuscular Disease , MS
- No Yes Nervous Condition
- No Yes Physical or Sexual Abuse
- No Yes Rheumatic Fever
- No Yes Thyroid Disease
- No Yes Ulcers, Crohn’s Disease or Colitis
- No Yes Unexplained Weight Gain or Loss
- No Yes Varicose Veins
- No Yes Other _____
- No Yes Surgeries, List _____

Marital Status: Single Married Other _____

How old were you when you had your 1st menstrual period? _____ years old.

How long between your menstrual periods? (From the 1st day of one period to the 1st day of your next) _____ days

How many days do you bleed? _____ days. Do you bleed between periods? Never Sometimes Often _____

Do you have pain or cramps with your period? No Yes What do you take to relieve your discomfort? _____

Have you ever had? (If Yes, when & describe treatment)

- No Yes Abnormal Pap Smear _____
- No Yes Chlamydia _____
- No Yes Genital Herpes _____
- No Yes Genital Warts _____
- No Yes Gonorrhea _____
- No Yes Syphilis _____
- No Yes Pelvic Infection, P.I.D. _____
- No Yes I.U.D. If Yes, what type _____

Are you currently sexually active? No Yes

In the past year how many sexual partners have you had? _____

What method of contraception or birth control, if any, are you presently using?

- Pills _____
- IUD Diaphragm Condoms Natural/Rhythm Tubal Vasectomy Depo-Provera
- Other _____

Are you currently trying to become pregnant? No Yes

Do you have any Children ? No Yes, Ages _____

Have you ever **been pregnant?** No Yes If Yes, how many of the following have you had?

- *Full Term_____ * Preterm/Premature_____ * Miscarriages_____ * Elective Terminations_____ * Tubal or Ectopic _____
- * Pregnancy Complications _____, Describe _____
- * Delivery Complications _____, Describe _____
- * Cesarean Delivery _____, Reason needed _____

Have any **members of your family** (parents, aunts, uncles, grandparents, brothers, sisters) ever had any of the following:

- No Yes Asthma
- No Yes Birth Defects
- No Yes Bleeding Tendencies
- No Yes Breast Cancer
- No Yes Cancer _____
- No Yes Colon Cancer
- No Yes Drug or Alcohol Abuse
- No Yes Diabetes
- No Yes Heart Attacks or Disease
- No Yes High Cholesterol
- No Yes Multiple Sclerosis
- No Yes High Blood Pressure
- No Yes Kidney Disease
- No Yes Liver Disease
- No Yes Mental Illness, Depression, Suicide
- No Yes Parkinson's Disease
- No Yes Physical or Sexual Abuse
- No Yes Stroke
- No Yes Thyroid Disease
- No Yes Other _____