

Ricki Pollycove M.D.

Patient Information

Name: First _____ Last _____

Name you wish to be called: _____

Mailing Address: _____

City _____ State _____ Zip code _____

Home# _____ Work# _____ Cell# _____

Is it ok to leave a detailed message at Home? _____ Work? _____ Cell? _____

Email address: _____

Date of Birth: _____ SS# _____

(Not Required)

Employer: _____ Title: _____

Brief description of occupation: _____

Employer address: _____

City: _____ State: _____ Zip code: _____

Marital status: _____ Spouse/Domestic Partner name: _____

Spouse/Domestic Partner Employer: _____

Spouse/Domestic Partner Work Phone: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Religious Preference/Practice: _____

Please give your insurance card to the receptionist. We will copy it for your chart to provide to outside laboratories. Dr. Pollycove is an out of network provider and payment is requested at the time of service. Your insurance will reimburse you at the out-of-network rate. To find out what you can expect to be reimbursed, please contact your insurance company directly.

Authorization to release information and/or payment:

I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the doctor to release all information necessary to secure payment.

Signature: _____ Date: _____

Ricki Pollycove M.D.

Medical History

Name: _____ Age: _____ Occupation: _____

Referred by: _____

Reason for visit: _____

Medical History

Please check if **you** or a **blood relative** has had any of the following:

- | | |
|--|---------------------------|
| <input type="checkbox"/> Frequent headaches or neurological disorder | Self _____ Relative _____ |
| <input type="checkbox"/> Thyroid problem | Self _____ Relative _____ |
| <input type="checkbox"/> High blood pressure or Heart Disease | Self _____ Relative _____ |
| <input type="checkbox"/> Asthma, Tuberculosis or any lung disorder | Self _____ Relative _____ |
| <input type="checkbox"/> Jaundice or Hepatitis | Self _____ Relative _____ |
| <input type="checkbox"/> Anemia or blood disorder | Self _____ Relative _____ |
| <input type="checkbox"/> Diabetes | Self _____ Relative _____ |
| <input type="checkbox"/> Cancer | Self _____ Relative _____ |

Please check if **you** have had either of the following:

- Stomach, bowel or gallbladder problems
- Bladder or kidney problems
- Do you frequently lose urine when you cough, laugh, sneeze? Yes _____ No _____
- Have you ever had a blood transfusion? Yes _____ No _____
- Other medical problems? Yes _____ No _____
 - If yes, please explain

- Are you allergic to any medications? Yes _____ No _____
 - If yes, what is the allergic reaction? _____
- Are you presently taking any medications? Yes _____ No _____
 - If yes, what medications (including hormones) are you taking?

- Mental health disorders, past or present therapy? Yes _____ No _____
 - If yes, please explain

Hospitalization/Surgery

Date

Illness/Operation

_____	_____
_____	_____
_____	_____
_____	_____

Habits

- Smoking _____ packs/day Number of years _____
- Drugs (marijuana, cocaine, other) Daily _____ Occasionally _____ Never _____
 - Addictions – past/present treatment? Yes _____ No _____
- Alcohol (beer, wine, other) Daily _____ Occasionally _____ Never _____
 - Alcoholism - past or present treatment? Yes _____ No _____

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Gynecological History

- ❖ First day of last menstrual period? _____
- ❖ Last Pap Smear? _____ with Dr. _____
- ❖ Have you had a Mammogram? Yes ___ No ___
 - If yes, date: _____ location: _____

Please check if you have had any of the following:

- Recurrent vaginal infections (yeast, bacterial vaginitis, etc.)
- Recent vaginal itching, unusual discharge, or odor
- Genital Herpes
- HPV
- Condyloma (warts)
- Pelvic infection (PID), Gonorrhea, Chlamydia, Syphilis
 - Do you want to be screened for these STDs? Yes ___ No ___
- Ovarian Cysts or Tumors
- Fibroids
- Endometriosis
- Infertility
- Abnormal bleeding
- Abnormal Pap Smears
- Breast discharge or lumps Self ___ Family ___
- Do you do monthly self breast exams? Yes ___ No ___
- Do you have regular periods? Yes ___ No ___
- Are you postmenopausal? Yes ___ No ___
 - If yes, year of last period: _____
- What do you use for contraception? _____
- DES exposure
- Sexual problems/abuse
- Sexual Orientation: Heterosexual ___ Homosexual ___ Bisexual ___
- Since 1979 have you been involved in any of the following situations?
 - Used IV drugs or had a partner who used IV drugs
 - Had sexual contact with a bisexual man or a man who has developed AIDS
 - Had 5 or more sexual partners within 3 years
 - Received blood products
 - Had donor artificial insemination (unless donor screened for AIDS)
 - Lived in or had a sexual partner who lived in areas where AIDS is endemic (Haiti, Burundi, Rwanda, Zaire, Congo, Tanzania, Kenya)
- Do you want to be screened for the antibody for the AIDS virus (HIV)? Yes ___ No ___

Pregnancy History

Times Pregnant ___ Abortions ___ Ectopic/Miscarriage ___ Premature Birth ___ Living Children ___

Born Mo/Yr. Weight Sex Weeks pregnant Vaginal/C-section Complications
