Name:_____

Email:_____

Date of Birth:_____

Initial Appointment Date:_____

How did you hear about us (circle)?				
Physician Referral	friend/family	Advertisement	Internet	TV

Medical History Form
Dr. Harriette Scarpero/ Kate Meriwether, NP

NEW PATIENTS: In order to best care for you, we would appreciate it very much if the following questions could be answered prior to your appointment.
RETURNING PATIENTS: Please review your responses below and make changes accordingly. Please date and initial below.

Patient Review Date and Initial:_____

Medical Problems/Serious Illnesses:_____
_____
_____

Medication Allergies:_____
_____
_____

Current Medications:_____
_____
_____

Past Surgeries:_____
_____
_____

Social History:
Do you currently smoke or have you ever smoked in the past? Yes____ No_____
If yes, how many packs per day do/did you smoke? _____ For how many years?_____
Do you have a history of alcohol abuse? Yes_____ No_____
Do you have a history of drug abuse? Yes _____ No _____

For Female Patients Only:
Number of pregnancies (including any miscarriages, abortions, etc.) _____
Number of living children _____
Number of vaginal deliveries _____
Number of Cesarean Sections (C-sections) _____
Delivery Complications: _____
Do you still have periods? Yes _____ No _____ If yes, how often? _____
Have you been through menopause? Yes _____ No _____ If yes, at what age? _____
Have you ever been on Hormone Replacement Therapy (HRT) Yes _____ No _____
If yes, what therapy and for how long? _____
Have you ever been diagnosed with a female related cancer? (breast, ovarian, uterine, cervical, vaginal)Yes ___No___