COMPLETE WOMENS CARE

Scott Berman, M.D.
2500 Nesconset Highway, Building 12A, Suite 45
Stony Brook, NY 11790
Phone: 631-675-9010 Fax: 631-675-9009

Please fill out this questionnaire completely and to the best of your ability.

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security #: _____

Street Address: _____

City, State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ E-Mail Address: _____

Please advise the best way for us to contact you: _____

Can we leave a message with someone else other than yourself to discuss your health/care and if so, who & a phone #: _____

Health Insurance Company: _____

Date of Birth of Insured: _____

Insured Party: _____ Relationship to Insured: _____

Member ID #:_____ Insurance Phone #:_____

How were you referred to us? _____

Name of Pharmacy you use for prescriptions: _____

Pharmacy Phone #: _____

Pharmacy Address: _____

Prescription/Medication History Authorization: For your convenience, information from your local pharmacy regarding prescriptions you are currently taking or have taken in the past will be provided to Complete Womens Care through our electronic medical records computer system.

Please list all medications that you are currently taking, including vitamins, aspirin, etc. _____

Please advise any allergies to medications, latex or seasonal:

_____

Please list any medical problems that run in your family:

_____

Please mark **all** medical problems that apply to you, that you have or had experienced:

____ Anorexia	____ Anxiety Disorder	____ Anemia
____ Appendicitis	____ Asthma	____ Abnormal Pap
____ Breast Problems	____ Brain Disorders	____ Breathing Disorder
____ Bleeding Disorders	____ Cancer	____ Chemotherapy
____ Chicken Pox	____ Chlamydia	____ Concussion
____ Cysts	____ Cataracts	____ Depression
____ Diabetes	____ Down Syndrome	____ Hearing Problems
____ Eating Disorders	____ Edema	____ Gastro Problems
____ Glaucoma	____ Gout	____ Hepatitis
____ Heart Disease	____ Hernia	____ Herpes
____ High B/P	____ Immunodeficiency	____ Infertility
____ Kidney Problems	____ Liver Problems	____ Menstrual Issues
____ Menopause Issues	____ Migraines	____ Nerve Problems
____ Pregnancy	____ Pain Management	____ Paralysis
____ Seizure Disorders	____Skin Disorders	____ Scoliosis
____ Sickle Cell	____ Thalassemia	____ Toxemia
____ Tuberculosis	____ Turners Syndrome	____ Ulcers

____ Other (Please note): _____

PREVIOUS SURGERIES

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

OBSTETRICAL HISTORY

Type of Delivery: _____ (M/F) Date: _____

Type of Delivery: _____ (M/F) Date: _____

Type of Delivery: _____ (M/F) Date: _____

Type of Delivery: _____ (M/F) Date: _____

When was your last menstrual period: _____

Please advise your height: _____ ft. _____ inches

Please advise your current weight: _____ lbs.

*Would you be interested in learning about our medical weight loss program, Take Shape For Life! _____ (Please advise Yes or No)

_____ Date: _____
(Patient's Signature)

_____
(Doctor's Signature)