UTICA
WOMEN'S SPECIALISTS

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Obstetrics and Gynecology

GYN History

Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Cell Phone: _____ Email: _____

Primary Insurance: _____ ID# _____

Policy Holder _____ Group # _____

Policy Holder SSN# _____ Policy Holder DOB _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

First Day of Last menstrual cycle: _____ Date of Last mammogram: _____

CURRENT PRESCRIPTIONS and OVER THE COUNTER MEDICATIONS					
Name of Medication	Dosage (total mg)	Number per day	Prescribing Doctor	Reason for medication	Side effects?

Surgeries in the Past Year: _____

_____

_____

Hormonal Related Issues: _____

_____

Family History Changes: _____

_____

_____

Any additional concerns or changes to your medical history in the past year: _____

_____

_____

_____