Mark Jacobs, MD, P.A.

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Please Fill Out Completely: *Pharmacy Phone No.*_____

Patient Name: _____ Date: _____

Age: _____ Number of Pregnancies: _____ Number of Children: _____

Medications you are taking: _____

Allergies: _____

Last Menstrual period: _____Cycles: Regular_____ Irregular:_____ Method of Contraception:_____

Reason for Visit:_____

Have you been treated for any of the following (circle all applicable)

Arthritis	*Glaucoma*	*Kidney disease*	*Stroke*
Asthma or pneumonia	*Heart problems or murmurs*	*Kidney stones*	*Thyroid disease*
Blood Clots	*Hepatitis*	*Lupus*	*Thyroid disease*
Cancer	*High blood pressure*	*Migraines*	*Tuberculosis*
Colon Problems	*High cholesterol*	*Seizure or epilepsy*	*Ulcers or reflux*
Diabetes	*Intestinal disease*	*Skin problems*	*Urinary infection*
Gallbladder disease			

List any surgeries you have had:_____

Do you have a family history of: *Diabetes, heart attack, stroke, high blood pressure, kidney disease, birth defects, inherited disease, cancer* **(Circle all applicable)**

General medical checkup/heart: _____Colonoscopy: _____

Please answer the following:

Do you perform breast Self-examination?	Y / N	Do you exercise?	Y / N
Do you feel any lumps?	Y / N	Walk the equivalent of one mile per day?	Y / N
Do you smoke? How Much?	Y / N	Do you take vitamins?	Y / N
Do you drink alcohol? How Much?	Y / N	Do you take Calcium? Y / N Vitamin D?	Y / N

Do not fill out below this line

Physical Exam: BP _____ Pulse _____ Height _____ Weight _____ Temp _____ UPT _____VAG: pH____KOH_____Wet_____

HEENT:	Pelvic:
Neck:	Ext. Genitalia:
Thyroid:	Urethra:
Chest:	Vagina:
Heart:	Cervix:
Breasts:	Uterus:
Abdomen:	Adnexa:
Extremities:	Ano-Rectal

DX:	Lab:	RX:

Thin Prep, Mammogram, Auto Occult, CBC, SMA, Lipid, T4 free, T3, TSH, FSH, Prolactin, E2, Progesterone, Testosterone, DHEA Sulfate, Wet Smear, Nickerson, Gen Probe, HIV,RPR, Herpes I, II, Quantitative HCG, UA, Urine Culture, Sex Hormone Binding Globulin, Bone Density, Vit D

Patient Information Sheet

Patient Information

Name (First) _____ (M.I) _____ (Last) _____

Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip Code _____

Best Daytime Phone # _____ Social Security # _____

Employer _____ Work # _____

Email _____

Referring Physician _____

Emergency Contact: _____

Responsible Party

Name _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth (Insured) _____ Social Security # _____

Work Phone #_____ Cell # _____

Employer _____

Employer Address _____

Insurance Information

Insurance Company _____ Phone # _____

Member ID # _____ Group # _____

Claims Address _____

Insured Name _____

Relationship to Patient _____

I hereby assign, transfer, and set forth to Mark Jacobs, MD,PA all of my right, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____

No changes to the information provided above

Patient Signature _____ Date _____