ADRIENNE L. SIMONE, M.D. F.A.C.O.G.
59 East 54th Street, Suite 82
New York, NY 10022
Tel 212-243-3033
Fax 212-546-0968

DATE: ________________

NAME:______________________________________ DOB: __________AGE:_________

CELL: ___________________________________ HOME TEL: ______________________
EMAIL:____
SINGLE: ____MARRIED:____ PARTNERED:____WIDOWED:____ PRONOUNS:_________
ADDRESS: ____ APT:_________
CITY: ____STATE: _______ ZIP:___________
ARE YOU A STUDENT? YES:_____ NO: ______ FULL TIME: ______ PART TIME:_______
OCCUPATION: ________________________ REFERRED BY: _______________________

EMERGENCY CONTACT INFORMATION:

NAME: __________________________________ PHONE: ________________________
RELATIONSHIP: ___________________________

INSURANCE INFORMATION:

PRIMARY INSURANCE: ____
INSURANCE ID: ______________________________ GROUP ID: ___________________
NAME OF INSURED PERSON: __________________ RELATIONSHIP: ______________
ADDRESS IF DIFFERENT FROM PATIENT: ____________________________________
CITY: __________________________ STATE: ____________ ZIP: __________________

CANCELLATION POLICY:

I, ____, UNDERSTAND THERE WILL BE A FEE OF **$300. 00** CHARGED FOR ANY MISSED OR CANCELED APPOINTMENTS MADE LESS THAN **24 HOURS** PRIOR TO MY APPOINTMENT TIME.

PATIENT SIGNATURE:________________________________ DATE:________________

PRIMARY CARE PHYSICIAN:

NAME: ____ PHONE: ______________________________
LAST PHYSICAL: ______________________________ BLOOD WORK:______________________
DERMATOLOGY EXAM: _____________________ OPHTHALMOLOGY EXAM:__________

MENSTRUAL HISTORY:

AGE OF FIRST CYCLE: ____________ LAST MENSTRUAL CYCLE: ___________
LENGTH OF CYCLE: ______________ CRAMPING WITH CYCLE:_____________

GYNECOLOGICAL HISTORY:

LAST PAP SMEAR:____________ RESULT:*________ LOCATION:______________________
MAMMOGRAM/SONO:_____________________ LOCATION:______________________
BONE DENSITY:___________________________ LOCATION:______________________
COLONOSCOPY:___________________________ LOCATION:______________________
TRANSVAGINAL SONOGRAM:_____________ LOCATION:______________________

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CHLAMYDIA* ( ) HPV* ( ) OTHERS* ( )___________________

GENITAL WARTS* ( ) SYPHILIS*( ) ___________________________

HERPES* ( ) TRICHOMONAS*( ) ___________________________

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PREGNANCY HISTORY:

TOTAL PREGNANCIES: ________ MISCARRIAGES:_________ ABORTIONS:_____________
DELIVERY HISTORY: ______________________ BREAST FEEDING: _____________
HOW LONG DID YOU BREASTFEED? ____________
COMPLICATIONS: ______________________________

BIRTH CONTROL HISTORY:

ORAL CONTRACEPTIVE:________________________ DATE: ___________________________
NAME OF IUD USED:____________________________ DATE: ___________________________
OTHER:____ DATE: ___________________________

PAST AND CURRENT MEDICAL HISTORY:

ALLERGIES TO MEDICATION:____

FOOD ALLERGIES: ____

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MEDICATION AND DOSAGE:

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SUPPLEMENTS / VITAMINS:____

PHARMACY PHONE NUMBER:____

MAIL AWAY PHARMACY:____

PERSONAL HISTORY

HEART DISEASE* ( )
DIABETES* ( )
KIDNEY DISEASE* ( )
ANEMIA* ( )
HYPERTENSION* ( )
DRUG USE* ( )
SEIZURE DISORDER* ( )
AUTO IMMUNE* ( )
OSTEOPOROSIS* ( )

LUNG DISEASE* ( )
THYROID DISEASE* ( )
MENTAL ILLNESS* ( )
CANCER* ( )
GENETIC DISEASE* ( )
INFERTILITY* ( )
CLOTTING DISORDER* ( )
STROKES* ( )
OTHER* ( )______________________

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FAMILY HISTORY

HEART DISEASE* ( )
DIABETES* ( )
KIDNEY DISEASE* ( )
ANEMIA* ( )
HYPERTENSION* ( )
DRUG USE* ( )
SEIZURE DISORDER* ( )
AUTO IMMUNE* ( )
OSTEOPOROSIS* ( )

LUNG DISEASE* ( )
THYROID DISEASE* ( )
MENTAL ILLNESS* ( )
CANCER* ( )
GENETIC DISEASE* ( )
INFERTILITY* ( )
CLOTTING DISORDER* ( )
STROKES* ( )
OTHER* ( )____________________
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PREVIOUS SURGERIES / DATES:

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REASON FOR VISIT:

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