Vagisha Sharma, MD PA

Your Name _____ Today's Date / /

Address _____ Date of Birth / / Age ____

City _____ State ____ Zip _____ Home Phone ( ) -

Occupation _____ Work Phone ( ) -

Social Security Number - - Cell Phone ( ) -

In Case of Emergency Notify _____( ) Employer _____

I hereby authorize and consent to Dr. Sharma and associates to examine me medically and/ or perform a Pap Smear and/or issue any other treatment she may in her judgement determine advisable for my medical well being. I authorize Dr. Sharma and her associate physicians to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physicians, or to assist with, aid in, or facilitate the collection of data for the purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, managed care organizations, IPA's, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary care physician or any other that is directly or indirectly responsible for my medical care or the payment thereof.

Signature: ***Date*** / /

How did you find out about us? _____

Insurance Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insured's Name (If Spouse or Parent)_____ ***Insured's D.O.B*** . / /

Insured's Social Security Number - - Employer _____

Insurance Company _____Group # _____ Phone#_____

Insurance Co. Address _____ City _____ State ___ Zip _____

Reason for Today's Visit: _____

Do you have any specific questions or problems that you would like to discuss today?

☐ No ☐ Yes _____

When was your Last Menstrual Period? _____***When was your last Pap Smear?*** _____

Have you seen any other doctors recently?	☐ No ☐ Yes	*Whom, Why?* _____
Are you currently taking any medication?	☐ No ☐ Yes	*List* _____
Do you take any vitamins or herbal supplements?	☐ No ☐ Yes	*List* _____
Do you have any allergies or sensitivities to medication?	☐ No ☐ Yes	*List* _____
Do you do examine your breasts monthly?	☐ No ☐ Yes	*How often?* _____
Have you ever had a mammogram?	☐ No ☐ Yes	*Results* _____
Are you taking calcium to prevent osteoporosis?	☐ No ☐ Yes	
Have you ever had a cholesterol test?	☐ No ☐ Yes	*Results* _____
Do you want testing for Sexually Transmitted Diseases (STD's)?	☐ No ☐ Yes	*Explain* _____
Do you have questions about sex or STD's?	☐ No ☐ Yes	_____
Do you have pain with sex?	☐ No ☐ Yes	*Explain* _____
Do you have any problems at home?	☐ No ☐ Yes	*Explain* _____
Has there been any change in your relationship with your partner?	☐ No ☐ Yes	*Explain* _____
Have you ever been tested for H.I.V.?	☐ No ☐ Yes	*Results* _____
Do you smoke?	☐ No ☐ Yes	*How much?* _____
Do you drink alcohol?	☐ No ☐ Yes	*How much / often?* _____
Do you use any street or recreational drugs?	☐ No ☐ Yes	*What type / often?* _____

Do you now, or have you ever, had any of the following? **[√]**

☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Kidney Problems
☐ No	☐ Yes	Anemia	☐ No	☐ Yes	Liver Disease or Tumor
☐ No	☐ Yes	Bleeding Tendencies	☐ No	☐ Yes	Lung Disease
☐ No	☐ Yes	Blood Clots in Leg (Phlebitis)	☐ No	☐ Yes	Migraines
☐ No	☐ Yes	Blood Transfusion	☐ No	☐ Yes	Mononucleosis
☐ No	☐ Yes	Breast Lump or Discharge	☐ No	☐ Yes	Neurologic Disease or Seizures
☐ No	☐ Yes	Bulimia or Anorexia	☐ No	☐ Yes	Neuromuscular Disease , MS
☐ No	☐ Yes	Cancer _____	☐ No	☐ Yes	Nervous Condition
☐ No	☐ Yes	Drug /Alcohol Dependency or Abuse	☐ No	☐ Yes	Physical or Sexual Abuse
☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Rheumatic Fever
☐ No	☐ Yes	Depression	☐ No	☐ Yes	Thyroid Disease
☐ No	☐ Yes	Gallbladder Disease	☐ No	☐ Yes	Ulcers, Crohn's Disease or Colitis
☐ No	☐ Yes	Heart Disease or Murmur	☐ No	☐ Yes	Unexplained Weight Gain or Loss
☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Varicose Veins
☐ No	☐ Yes	Jaundice or Hepatitis	☐ No	☐ Yes	Other _____
☐ No	☐ Yes	Fractures, List _____	☐ No	☐ Yes	Surgeries, List _____
☐ No	☐ Yes	Hospitalizations, List _____			

Marital Status: ☐ Single ☐ Married ☐ Other _____

How old were you when you had your ***1st*** menstrual period? _____*years old.*

How long between your menstrual periods? (From the 1st day of one period to the 1st day of your next) _____ *days*

How many days do you bleed? ____ *days*. *Do you bleed between periods?* ☐ Never ☐ Sometimes ☐ Often ____

Do you have pain or cramps with your period? ☐ No ☐ Yes *What do you take to relieve your discomfort?* _____

Have you ever had? *(If Yes, when & describe treatment)*

☐ No	☐ Yes	Abnormal Pap Smear _____	☐ No	☐ Yes	Chlamydia _____
☐ No	☐ Yes	Genital Herpes _____	☐ No	☐ Yes	Genital Warts _____
☐ No	☐ Yes	Gonorrhea _____	☐ No	☐ Yes	Syphilis _____
☐ No	☐ Yes	Pelvic Infection, P.I.D. _____	☐ No	☐ Yes	I.U.D. If Yes, what type _____

Are you currently sexually active? ☐ No ☐ Yes

In the past year how many sexual partners have you had? _____

What method of contraception or birth control, if any, are you presently using?

☐Pills_____☐IUD ☐Diaphragm ☐Condoms ☐Natural/Rhythm ☐Tubal ☐Vasectomy ☐Depo-Provera ☐Other _____

Are you currently trying to become pregnant? ☐ No ☐ Yes

Do you have any Children ? ☐ No ☐ Yes, Ages _____

*Have you ever **been pregnant?*** ☐ No ☐ Yes *If Yes, how many of the following have you had?*

Full Term___ Preterm/Premature___* Miscarriages___* Elective Terminations____ * Tubal or Ectopic _____

* Pregnancy Complications ___, Describe _____
* Delivery Complications ___, Describe _____
* Cesarean Delivery ___, Reason needed _____

*Have any **members of your family** (parents, aunts, uncles, grandparents, brothers, sisters) ever had any of the following:*

☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Multiple Sclerosis
☐ No	☐ Yes	Birth Defects	☐ No	☐ Yes	High Blood Pressure
☐ No	☐ Yes	Bleeding Tendencies	☐ No	☐ Yes	Kidney Disease
☐ No	☐ Yes	Breast Cancer	☐ No	☐ Yes	Liver Disease
☐ No	☐ Yes	Cancer _____	☐ No	☐ Yes	Mental Illness, Depression, Suicide
☐ No	☐ Yes	Colon Cancer	☐ No	☐ Yes	Parkinson's Disease
☐ No	☐ Yes	Drug or Alcohol Abuse	☐ No	☐ Yes	Physical or Sexual Abuse
☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Stroke
☐ No	☐ Yes	Heart Attacks or Disease	☐ No	☐ Yes	Thyroid Disease
☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	Other _____