Female Patient Questionnaire & History

Name: ________________________________________________Today's Date: __________________
(Last) (First) (MI)

Date of Birth: _________ Age: ______ Occupation: _____________________________________

Home Address: ______________________________________________________________________

City: _________________________________ State: __________________Zip: ___________________

Cell Phone #: _____________________________ Work Phone #: ___________________________
E-Mail Address: ________________________________ May we contact you via E-Mail? ( ) YES ( ) NO

Preferred Pharmacy: ___________________________ Pharmacy phone#: ____________________

**Insurance information for Lab order purposes:**

Primary Insurance Company: ______________________ Name of Policy holder : __________________
Mailing address: _________________________________ City:__________ State: ____ Zip: __________

Relationship to Insured: ________________________ Policy Holder's DOB: _____________________

Policy#: _____________________________________ Group Name/Number: ______________________

In Case of Emergency, Contact: ____________________________ Relationship: _____________________
Contact Number: _________________________________________

PCP's Name: ___________________________________________ Phone#: _________________________
Address: _______________________________________ City: _____________ State: ___ Zip: ________

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below, you are giving us permission to speak with your spouse or significant other about your treatment.

Name: __________________________________________ Relationship: ___________________________
Contact number(s): _______________________________________________________________________