
**Welcome! We are pleased you chose Elite for all your healthcare needs. We request that you fill this packet out in its entirety. We realize it is lengthy but it helps us provide you with the best service and care possible.**

Last Name:_____ First Name:_____ M.I._____

DOB:_____/_____/_____ Social Security:_____-_____-_____

Address:_____ Apt#_____ City:_____ State:_____ Zip:_____

Home: (_____)_____-_____ Cell: (_____)_____-_____ Email:_____

Marital Status:_____ Ethnicity:_____ Preferred Language:_____

How did you hear about us? Please specify a name if it applies._____

Preferred Pharmacy:_____ Phone: (_____)_____-_____ Street Address: _____

Emergency Contact Name:_____ Relation:_____ Phone: (_____)_____-_____

Your Employer:_____ Phone: (_____)_____-_____ Your Occupation:_____

Primary Care Physician (Specify Name):_____ Phone: (_____)_____-_____

***Please Note: <u>We do not accept checks as a form of payment.</u> We do however accept cash and major credit cards. Please have your form of payment ready when you complete your packet if payment applies to your visit.**

Today's Date:_____/_____/_____ Insurance:_____

**Financial Policy (Please Read & Sign)**

The purpose of this form is to clarify our office and collection policy. Charges for medical services are due and payable at the time services are rendered. If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay certain fees (co-insurances, deductibles, copays, etc) for medical care. You are responsible for the payment of the bill regardless of the status of your insurance claim.

Patients who are on Medicare Insurance are responsible for their annual deductibles until the full amount of deductible has been met unless you have a secondary insurance that we are contracted with. Please notify our staff by providing your insurance cards (primary & secondary at the time of your visit. We will make efforts to contact you regarding pending bills (statements and phone calls). But ultimately it is your responsibility to reach out to our office to pay your balance or set up an arrangement. After 90 days of no contact/ payments, we will send your account to collections.

**Signature_____**

Date of Last Annual Exam:_____/_____/_____

Reason for today's visit:_____

Allergies to medications:_____

| Please list your current medications: |
|---|
| |

| | | | |
|---|---|---|---|
| Date of last menstrual period | | Duration of Flow (number of days | |
| Frequency of Cycle | | If Post Menopausal, Age at Menopause | |
| Flow | | Age at Menarche (First Period) | |
| Menses Monthly | | Current Birth Control Methods | |

Obstetrical History (Please List Totals):

| Full Term | Premature | Termination | Miscarriage | Ectopics/ Tubal | Twins | Living Children |
|---|---|---|---|---|---|---|
| | | | | | | |

Past Medical History: (Please circle what applies to you)

| | | | |
|---|---|---|---|
| Abnormal Pap Smear | Anemia/ blood disorder | Disrupted Monthly Cycle | Anxiety Disorder |
| Arthritis | Asthma | Bipolar Disease | Blindness |
| Blood Transfusion | Breast Cancer | Broken Bones | Cancer- Other |
| Cardiovascular Disease | Breast Cancer | Cervical Cancer | Cervical Dysplasia |
| Chlamydia | Gall Bladder Inflammation | Colitis | Colon Cancer |
| Genital Warts | COPD | Crohn's Disease | Depression |
| Diabetes | Deep Vein Thrombosis | Ear Problems | Ectopic/ Tubal Pregnancy |
| Endometrial Cancer | Endometriosis | Epilepsy | Eye Problems |
| Factor V Leiden | Fibroids | Gestational Diabetes | GI Problems |
| Glaucoma | Gonorrhea | Heart Arrhythmia | Heart Attack |
| Head Injury | Hepatitis/ Jaundice | High Cholesterol | Herpes |
| HPV | Molar Pregnancy | High Blood Pressure | Insomnia |
| Chronic Bladder Inflammation | Irritable Bowel Syndrome | Kidney Stones | Breast Cancer |
| Lung Cancer | Lupus | Skin Cancer | Migraines |
| Motor Vehicle Accident | Osteoporosis | Ovarian Cancer | Paget's Disease |
| Pancreatitis | Peptic Ulcer Disease | Pelvic Inflammatory Disease | Pneumonia |
| Polycystic Ovarian Syndrome | Psoriasis | Rheumatic Fever | Sarcoidosis |
| Sjogren's Syndrome | Stress Incontinence | Stroke | Substance Abuse |
| Superficial Phebitis | Thyroid Problems | TIA | Urge Incontinence |
| Unusual Childhood Diseases | Vaginal Dysplasia | Vulvar Cancer | Vulvar Dysplasia |

Social History (Please Circle)

Education Level: 8th Grade 12th Grade High School Grad 2 Year College 4 Year College Grad School

Sexually Active: Yes No

Smoking: Never Smoked Former Smoker Current Smoker Packs Per Day_____ Years_____

Tobacco Use: Yes No Years_____

Alcohol Intake: None Socially Drinks Per Day

Recreational Drug Use: Yes No Years_____

Caffeine Intake: None Occasional Moderate Never

Diet: Regular Vegetarian Vegan Gluten Free Specific Carbohydrates

Exercise Level: None Occasional Moderate Never

Stress Level: Low Medium High

Sexual Orientation: Heterosexual Lesbian Bisexual

Is a blood transfusion acceptable in an emergency: Yes No

Are you in a safe and violence free relationship/ home environment? Yes No

Family History

| Illness | Yes | Relative | Illness | Yes | Relative |
|---|---|---|---|---|---|
| Diabetes | | | Breast Cancer | | |
| Stroke | | | Uterine Cancer | | |
| Heart Disease | | | Ovarian Cancer | | |
| High Blood Pressure | | | Colon Cancer | | |

Surgical History: (Please list ALL Surgeries/ Operations/ Hospitalizations)

Date of Surgery / / Reason_____

Date of Surgery / / Reason_____

Date of Surgery / / Reason_____

**Please Sign: I verify that the above information is accurate to the best of my knowledge and memory.**

**Please circle all items you are experiencing below. If the symptoms do not apply to you, please leave the form completely blank. No name needed. Thank you.**

**General Health:** Extreme Fatigue, Fever, Weight Gain (_____lbs) Weight Loss (____lbs)

**Skin:** Abnormal, Moles, Rashes

**Breasts:** Nipple Discharge, Breast Masses, Breast Pain

**Respiratory:** Severe Chest Pain, Persistent Cough

**Cardiovascular:** Severe Chest Pain, Persistent Heart Palpitations

**Gastrointestinal:** Nausea, Vomiting, Diarrhea, Abdominal Pain, Rectal Bleeding

**Genitourinary:** Blood in your urine, Abnormal bleeding, Incontinence, Vaginal Itching, Odor, Discharge

**Menstrual mood/ symptoms:** Extreme Irritability, Breast Pain/ Tenderness

**Menopausal Symptoms:** Intolerable Hot Flashes, Night Sweats, Impaired Concentration, Insomnia

**Sexual:** Severally Decreased Libido, Orgasmic Dysfunction, Painful Sex

**Musculoskeletal:** Muscle Weakness, Severe Back Pain

**Psych:** Depression, Uncontrolled Crying, Alcoholism, Drug Abuse, Sleep Disturbances

**Are you having Menstrual Problems? If YES please circle below:**

**Onset/ Timing:** Present Cycle, Past 2 Cycles, Past 3-5 Cycles, Past 6+ Cycles, Every Cycle, Occasional, New Onset Bleeding, Irregular, Menopausal

**Duration:** <7 days/ month, 7- 10 days/ month, 10- 15 days/ month, daily bleeding, almost daily, 1-2 days between cycles

**Quality:** Spotting, Light, Moderate, Heavy Passing Clots

**Severity:** Changing Pad/ Tampon every 1-2 hours, Requires Double Protection, Interferes with Daily Activities, Requires getting up at Night

**Context:** Occurs Midcycle, Occurs After Intercourse, Occurs Between Normal Cycles, Post Menopausal Post Menopausal, Positive Pregnancy Test, Current HRT Use, History of Endometriosis, History of Fibroids, History of STD/ Pelvic Infection

**Associated Symptoms:** Pelvic Pain, Occurs After Intercourse, Fatigue, Dizziness, Anemia/ Iron Supplements, Bloating, Change in Bowel Function, Change in Urinary Function, Vaginal Itching

**Anything Else You Would Like Us To Know About How You Are Feeling? _____**


Test Results Consent

I _____ give permission to the person/ persons listed below to receive test results on my behalf.

Name: _____

Phone: _____

Name: _____

Phone: _____

I _____ do not authorize for my test results to be given to anyone other than myself.

Signature: _____

Best Phone Number to reach you: _____


**REQUEST FOR MEDICAL RECORDS**

I _____, REQUEST THAT A COPY OF MY MEDICAL RECORDS BE RELEASED FROM THE FOLLOWING OFFICE:

Dr. _____

Phone #: _____

Fax #:_____

Address: _____

_____

And Forwarded to: Dr Lanalee Araba Sam
2466 East Commercial Blvd Ste 101
Fort Lauderdale, FL 33308
(P) 954-776-4877 (F) 954-776-1399

Patient Name:_____ Date of Birth: / /

Patient Signature:_____ Today's Date: / /