The Center for Menstrual Disorders

Rochester, New York

Patient Information Sheet

Please supply us with the following information:

Name: _____Date of Birth_____

Present mailing address_____

How were you referred to us? _____

Best way to reach you _____Best time to reach you_____

Please provide us with the name and phone number of your primary care physician_____

_____

Name and phone number of your gynecologist_____

Number of Living Children_____

Have you ever had a Cesarean section ☐ Yes ☐ No

Have you ever had a tubal ligation ☐ Yes ☐ No

Your approximate Height _____ (feet and inches) Your approximate weight _____lbs.

Significant medical problems

☐ obesity ☐ diabetes ☐ hypertension ☐ asthma

☐ anxiety ☐ depression ☐ bleeding disorder ☐ history of transfusions

☐ Excessive alcohol use ☐ History of substance abuse

☐ History of heart attack or strokes ☐ Heart disease ☐ Lung disease

☐ Migraine headaches ☐ Seizures ☐ Dental appliances

☐ Other significant medical problems _____

Medications (PLEASE LIST HOW OFTEN YOU TAKE IT AND THE DOSE)

_____

_____

_____

_____

_____

_____

_____

Allergies:

Please list any medication allergies:_____

Are you allergic to LATEX?

Menstrual History

When did your present problem begin? _____

Please describe your problem in depth. Try to include as much information about any prior surgery, emergency room visits and tests that you have obtained. Try to keep under 300 words.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How can we best help you?_____

LIST ALL PREVIOUS SURGICAL PROCEDURES/OPERATIONS

_____

_____

_____

_____

_____

Is there anything else you would like us to know about you or your family? _____

_____

Please e-mail this completed form to: moe2020@cmdrc.com

or FAX to 585 473 8853