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_______________________________

Home Phone__________________ Cell Phone__________________ Work Phone__________________

Email Address_________________________________

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

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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)

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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.

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How can we best help you?____

LIST ALL PREVIOUS SURGICAL PROCEDURES/OPERATIONS

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

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

or FAX to 585 473 8853