Renaissance Health and Surgical Associates, PC.
New / Established Patient Information

Date_____ Name_____ DOB_____ Primary Care Doctor_____

Have you had a: ___Tubal Ligation ___Appendectomy ___Hysterectomy ___Gallbladder Surgery

Have you had any other surgeries, not listed above?_____

Have you had any hospitalizations?_____

Do you have any new medical conditions?_____

Do you have a latex allergy? YES NO

Health Maintenance-Indicate the month and year that the following were last done.
PAP smear ___ Mammogram ___ Breast Exam ___ Colonoscopy ___ Thyroid Level ___ Cholesterol Level ___
Vaccinations (Tetanus___ Influenza___ Pneumovax __ HPV___)

Habits (circle) Alcohol Drug Use Tobacco Use *(now or in past)*

Do you exercise regularly? (more than 3 times per week) YES NO

Do you have 4 servings of dairy products daily or take calcium supplements? YES NO

Have you ever been abused or injured by someone you know? YES NO

Do you feel threatened by anyone in your household? YES NO

Marital status: Single Married Separated Divorced Widowed

Family History (please list family members who have had each)
Cancer _____ Thyroid Disease _____ Stroke/Heart Attack _____ Arthritis _____
Diabetes _____ Osteoporosis _____ Hypertension _____ None of the above_____

Below are risk factors for cervical and/or vaginal cancer—please check all that apply.

___ Sexual activity when less than 16 years of age
___ Five or more sexual partners in a lifetime
___ Sexually transmitted infection in past including gonorrhea, chlamydia, PID
___ Your mother took DES when she was pregnant with you
___ HIV positive
___ No PAP test done for last seven years
___ Fewer than three negative Pap tests
___ Current smoker
___ You have used birth control pills for five years or more
___ None of these apply to me

Are you sexually active? YES NO

How many pregnancies have you had? ___ How many children did you give birth to? ____

Your above medical history is very important and effects my management of your current health. Please take care to provide a thorough and accurate a record of past or current problems. Please sign below to indicate that you have provided the above information yourself and have not withheld or misrepresented your medical history.

Patient Signature: _____ RENA AZAR, MD