

**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
- Pelvic infection in past including gonorrhea, chlamydia, PID
- Your mother took DES when she was pregnant with you
- HIV positive
- No PAP smear done for last seven years
- Abnormal PAP smear in the past showing precancerous changes
- None of these apply to me

Are you sexually active? YES NO

How many pregnancies have you had? \_\_\_\_\_ How many children do you have? \_\_\_\_\_

Your above medical history is very important and affects 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