Lake OB-GYN Associates of Mid-Florida, LLC

601 E Dixie Ave., #401, Leesburg, FL 34748 (352) 787-1535 / 1400 US Hwy. 441, Bldg. 950, The Villages, FL 32159 (352) 259-5649

Established MEDICARE Patient Information for: _____

PRINTED PATIENT NAME *DOB*

Douglas Moffett, MD / Mitra Mossaddad, MD / Teresa Mendez, APRN

PLEASE CIRCLE YOUR PROVIDER

Any changes in your "PAST MEDICAL HISTORY OR FAMILY HISTORY" since your last visit with us?

NO / YES If YES, what: _____

SOCIAL HISTORY: **Tobacco Use:** NO / YES **Alcohol use:** NO / YES **Caffeine Use**: NO / YES

Seat Belt Use: NO / YES **Domestic Violence**: NO / YES **Drug Use:** NO / YES **Exercise Regularly:** NO / YES

REVIEW OF SYSTEMS: Do you **CURRENTLY** have any of the following symptoms?

Headaches	___	Depression	___	Dizziness	___
Night Sweats/Hot Flashes	___	Loss of consciousness	___	Water retention/swelling feet	___
Mood swings	___	Breast mass/soreness	___	Fatigue	___
Nipple discharge or bleeding	___	Muscle weakness	___	Gas	___
Indigestion/Heartburn	___	Nausea	___	Poor Appetite	___
Diarrhea	___	Constipation	___	Blood in bowel movements	___
Weight Loss	___	Painful urination	___	Blood in urine	___
Coughing up blood	___	Wheezing	___	Trouble walking	___
Glasses/contacts	___	Painful intercourse	___	Shortness of breath	___
Chest pain	___	Skin rash or itching	___	Jaundice (yellow skin)	___
Incontinence	___	Vaginal itching/irritation	___	Vaginal discharge	___
Post-menopausal bleeding	___	Vomiting	___	Weight Loss	___
Other: _____					

Any **NEW ALLERGIES** since your last visit to us? NO / YES- If YES, what: _____

Any **NEW SURGERY** since your last visit to us? NO / YES- If YES, what: _____

Any **HISTORY OF ABNORMAL** Pap smears? NO / YES- If YES, when: _____

_____ _____

Patient's Signature Date

****TURN OVER****

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PATIENT NAME:_____ DOB:_____

Please list all of your MEDICATIONS:

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I hereby consent to services, treatment and diagnostic procedures, including but not limited to medications, lab tests and/or a medically indicated physical examination. This may include, but is not limited to:

-a gynecological exam, which may include a rectal exam and/or a pelvic exam;
-an ultrasound exam, which may include a probe placed in the vagina;
-a rectal exam;
-examination of external genitalia

This will be performed by Douglas Moffett, MD and/or Mitra Mossaddad, MD and/or Teresa Mendez, APRN. This consent will remain active until I withdraw my consent in writing.

_____ _____

Patient's Signature Date

_____ _____

Or Personal Representative Signature Description of Personal Representative's Authority