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 Patient Information for ____ ________________

PRINTED PATIENT NAME *DOB*

I am here to see: Dr. Alfred Moffett / Dr. Douglas Moffett / Dr. Michelle Wood / Dr. Lauren Britt / Dr. Kaitlin Lee

CIRCLE YOUR DOCTOR

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CHIEF COMPLAINT: I am here today for my ANNUAL WELL WOMAN EXAMINATION:________________

Patient Initials

Last Menstrual Period was:_______________ Are my cycles regular? YES / NO

My cycles occur every _____ days and last _____ days Current form of birth control?:______________________

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

NO / YES If YES, what:____

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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

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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	___
Urinary problems	___	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	___
Vomiting	___	Weight Loss	___	Other:______________________________	

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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:_________________________________

Which lab does your insurance require specimens be sent to? **QUEST / LabCorp / CFHA** *(circle one)*

____ ___________________________

Patient's Signature Date

TURN OVER TO LIST YOUR MEDICATIONS

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PATIENT NAME:_____ DOB:_____

Please list all of your MEDICATIONS below:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

_____ _____

Patient's Signature Date