MISSOURI DELTA
WOMEN'S CARE CENTER

Dear New Patient,

Thank you for choosing Missouri Delta Women's Care Center!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐ Patient History ☐ Patient Assessment
☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

We look forward to meeting you. If you have any questions, please let us know!

Fallan Mayabb, MD
David Stroud, MD
Jennifer Waller, MD
Jane Eaves, WHNP
Sherry Welker, WHNP
1013 N. Main
Sikeston MO 63801
(573) 472-7535
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MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI

PATIENT INFORMATION
(to be completed by patient)

Date: _____

Name: First _____ Middle _____ Last _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____ Race _____ Religion _____

Social Security Number _____ Maiden/Other Name _____ Family Doctor _____

Patient Address _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Email Address _____

Patient Employer _____

Address: _____

City/State/Zip _____ Phone _____

Preferred Pharmacy _____

Next of Kin

Spouse/Father/Mother Name _____ D.O.B. _____

(Spouse or Parent if Patient is under 18 years of age)

S.S.N.# _____ Cell Phone Number _____

Address if different from above _____

Spouse/Parent Employer _____

Address _____

City/State/Zip _____ Phone _____

Closest Relative NOT Living With You

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Person to Notify (other than Next of Kin)

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON MISSOURI
Patient Assessment

DATE: _____ NAME: _____ DOB: _____

Do you have an Advance Directive (i.e. Living Will, Power of Attorney, etc)? Yes No

If yes, which one and do we have a copy? _____

Please check any immunizations you've had:

Flu Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

HPV Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

Pneumonia Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

TDAP Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

□ Other: _____ Where? □ at MDMC □ other facility

Do you smoke? _____ If yes, how long? _____ How many packs per day? _____

Female
When was your last?
Mammogram? _____
Pap Smear? _____
Colonoscopy? _____

Male
When was your last?
PSA? _____
Colonoscopy? _____

If Diabetic:
When was your last?
Hgb A1C? _____ Foot Exam? _____ Eye Exam _____

Have you had any visits to the Emergency Room or Hospital stay since your last office visit?

If yes, When? _____ Why? _____

Do you see other physicians/providers besides your Primary Care Physician?

If yes, Name of Provider/Specialty _____

Reason? _____

Are you having any pain? Yes No Please circle the number that describes your pain.

Location: _____

0	1	2	3	4	5	6	7	8	9	10
None		mild		mod		severe		very severe		worse

Have you had any falls that have resulted in injury in the past year? _____

If yes, How Many? _____ Type of injury? _____

Do you have any of the following?

□ CAD (Coronary Artery Disease) □ Diabetes □ Hypertension

What level of education have you completed? _____

Missouri Delta Physician Services

Missouri Delta Physician Services
Women's Care Center

Fallan Mayabb, MD / David W. Stroud, MD / Jennifer Waller, MD
Jane Eaves, WHNP-BC / Sherry Welker, WHNP-BC

GYN HISTORY

NAME_____ D.O.B. _____ / _____ / _____

OCCUPATION _____

TODAY'S DATE _____ / _____ / _____ REFERRED BY: _____

REASON FOR VISIT _____

PREGNANCY HISTORY:

TIMES PREGNANT _____ PREMATURE BIRTHS _____ MISCARRIAGES _____

ABORTIONS _____ LIVING CHILDREN _____

PLEASE FILL OUT THE FOLLOWING IF YOU ARE NOW PREGNANT:

NO.	BORN (MO/YR)	WEIGHT/SEX	TYPE OF DELIVERY	DOCTOR	PROBLEMS

MENSTRUAL / SEXUAL HISTORY:

AGE AT ONSET OF PERIODS: _____YEARS OLD DATE OF LAST PERIOD _____ / _____ / _____

PERIODS ARE: ☐ REGULAR ☐ IRREGULAR

AGE AT FIRST INTERCOURSE _____ YEARS OLD

HAVE YOU HAD THREE OR MORE SEXUAL PARTNERS TO DATE? _____

DO YOU HAVE PAIN WITH INTERCOURSE? _____

CONTRACEPTION:	**PAST**	**PRESENT**
INTRAUTERINE (IUD)	_____	_____
DIAPHRAGM	_____	_____
FOAM, CONDOMS	_____	_____
BIRTH CONTROL PILLS	_____	_____ NAME OF PILL _____

PAST MEDICAL HISTORY (PLEASE LIST ALL MEDICAL PROBLEMS: DIABETES, HIGH BLOOD PRESSURE ETC.)

_____

_____

_____

_____

MEDICATIONS:

DRUG NAME	DOSE
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES TO ANY MEDICINE? ☐ Yes ☐ No

_____ _____

_____ _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE PAST WITH DATE:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HABITS:

DO YOU SMOKE? ☐ YES ☐ NO

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

HAVE YOU USED STREET DRUGS? ☐ YES ☐ NO

FAMILY HISTORY:	**AGE (IF LIVING)**	**AGE AT DEATH**	**CAUSE/MEDICAL PROBLEM**
FATHER:	_____	_____	_____
MOTHER	_____	_____	_____

PLEASE CHECK ANY OF THE FOLLOWING IN YOUR FAMILY:

BREAST CANCER _____

OVARIAN CANCER _____

COLON CANCER _____

HEART DISEASE _____

DIABETES _____

REVIEW OF SYSTEMS: (PLEASE CIRCLE THE NUMBER OF ANY CONDITION YOU MAY HAVE OR HAVE HAD IN THE PAST):

1. SEIZURE OR CONVULSIVE DISORDER
2. SEVERE HEADACHES OR FREQUENT ONES
3. UNUSUAL SKIN LESIONS, HAIR GROWTH OR LOSS
4. HEART MURMUR OR RHEUMATIC FEVER
5. IRREGULAR OR FAST HEART BEAT
6. STOMACH, BOWEL, OR GALLBLADDER TROUBLE
7. RECURRENT CONSTIPATION OR DIARRHEA
8. RECTAL BLEEDING OR BLOOD IN STOOLS
9. BLADDER INFECTIONS OR BURNING WITH URINATION
10. KIDNEY INFECTION
11. BLOOD CLOT IN LEGS OR LUNG
12. FREQUENT FEELINGS OF NERVOUSNESS, LONELINEES, DEPRESSION
13. CONCERN OVER WORK OR FAMILY PROBLEMS
14. TROUBLE SLEEPING
15. HAD GONORRHEA, PELVIC INFECTION OR GENITAL WARTS
16. HAD HERPES
17. HAD AN ABNORMAL PAP SMEAR
18. VISUAL PROBLEMS OR WEAR CORRECTIVE GLASSES

PATIENT SIGNATURE _____

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: _____

Date:_____

□ Patient was unable /unwilling to sign acknowledgment.

Reason: _____

Staff initials: _____

Date: _____

Time: _____

Below is a list of people that may receive full disclosure of my medical information:

_____

_____

_____

Copy of Notice was included in patient's Admission Information Packet