Abilene Physicians Group
Nicole Koske Bullock, D.O.
OB/GYN

Thank you for providing the information below. You can be brief, but please include any information that you feel would be valuable to us. Thank you for choosing us, to care for you!

Name: _____ Age: _____ DOB: _____

Primary Care Physician: _____

Other physicians that care for you: _____

For what reason did you schedule your visit with us? Annual or Problem (please list below)

_____

_____

_____

Please list any medical problems you have had or any hospitalizations (and when diagnosed/treated):

_____

_____

_____

Please list any surgeries you have had and when you had them:

_____

_____

_____

Please list any medications and dosages you are on (include herbal meds/vitamins) :

_____

_____

_____

Do you have any drug allergies? Yes/No (circle one) if yes, please list below:

_____

When was your last pap smear? _____ Have you had an abnormal pap smear? Yes/No

If yes, what was abnormal about it? _____

When was your last menstrual period? _____; at what age did you start having menstrual periods? _____; how many days are between the 1st day of your period until the 1st day of your next period? _____ How many days do your periods last? _____

Are your periods heavy and/or painful? Yes/No

Do you use a birth control method? Yes/No if so, what is it? _____

Please list any sexually transmitted diseases you have had:

_____

List pregnancies you have had (including miscarriages or terminations); Include complications:

_____

_____

When was your last mammogram? _____; was it abnormal? _____

When was your last colonoscopy? _____

When was your last DEXA (bone density) scan? _____

Do any diseases run in your family? (Circle or list any others below) Birth defects – Osteoporosis High blood pressure – Diabetes – Stroke – Blood clothing problems – Breast cancer – other cancer:

_____

_____

Do you drink alcohol? Yes/No How much? _____ Do you use illicit drugs? _____

Do you smoke tobacco or use nicotine products? _____ How much? _____

(Optional) What type of occupation do you do? (Of if you are a student, where do you go to school?) _____

Thank you for supplying this information. Please feel free to write in any other information you think would be helpful to us. Bring this completed form with you on the day of your visit. If possible, please bring any information from previous medical evaluations that would be pertinent to your visit.

I understand that all charges are due at the time of the visit. I understand that prenatal fees (if applicable) are due by the 7th month (28 weeks of gestation).

Signature: _____ Date: _____

Other information you would like to provide:

_____

_____

_____