Thank you for choosing Presidential Women's Center. Please take your time and complete this personal and medical information form completely. If you have any questions you will have an opportunity to speak with someone privately. If there is anything we can do to make your experience better, please inform us and we will do our best to accommodate your needs.

Personal Information

Patient Name:_____
First Middle Last

Address_____City_____State_____ Zip_____

Home Phone_____ Cell _____Work_____

Date of Birth_____ Age_____ Marital Status_____ Race_____

Employer_____ Occupation_____

How were you referred to our office? _____ Religious Preference_____

Emergency contact _____Phone _____Relationship to you_____

Person driving you home _____Phone _____Relationship to you_____

Do you have Medicaid? Y N Do you have medical insurance? Y N

Reproductive History:

Date	Vaginal Delivery	C-Section	Complications Y/N Describe:

Date	Abortion	Miscarriage	Ectopic	Complications Y/N Describe:

Do you have a bicorniated, separated or heart shaped uterus? Y N