Dr. Lanalee Araba Sam
Diplomate American Board of Obstetrics & Gynecology
MEDICAL DIRECTOR

Elite Obstetrics & Gynecology

Specializing in: Minimally Invasive Laparoscopic & Robotic Surgery • VIP Obstetrical Packages

WELCOME – To the office of DR. LANALEE ARABA SAM

OUR MISSION:
TO PROVIDE EXCEPTIONAL MEDICAL SERVICES THAT MEET AND EXCEED OUR PATIENTS' NEEDS AND EXPECTATIONS.

(PLEASE ASSIST OUR EFFICIENCY BY FILLING OUT THE NEW PATIENT FORM BELOW)

PATIENT INFORMATION

DATE:____________________ NAME: ____________________ AGE: __________

ADDRESS: ____

CITY: ____________________ STATE: ____________________ ZIP:__________

EMAIL: ____

HOME#: ____________________ CELL#: ____________________

(PLEASE CIRCLE YOUR PREFERRED CONTACT #)

OCCUPATION: ____

PLEASE CIRCLE OR CHECK ALL THAT APPLY TO YOUR CURRENT STATUS:

Same Sex Partner(s) ❍ SINGLE ❍ MARRIED ❍ DIVORCED

Male Partner(s) ❍ SINGLE ❍ MARRIED ❍ DIVORCED

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME OF CONTACT PERSON: ______________________________

CONTACT'S PRIMARY CELL OR CONTACT#: ______________________________

What is the primary reason for your visit today? ______________________________

How did you hear about Dr. Sam:______________________________?

2466 E. Commercial Blvd. Suite 101 Ft. Lauderdale, Florida 33308 USA T: **954.776.4877** F: 954.776.8171 drsam@eliteobgyn.com www.eliteobgyn.com

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YOUR GENERAL MEDICAL HISTORY:

Note – If you do not feel comfortable answering any of the following questions please leave it blank and discuss it with Dr. Sam in person.

Do you have any Major Medical Illnesses (please circle if yes):____________________

❍ HIGH BLOOD PRESSURE ❍ HIGH CHOLESTEROL ❍ DIABETES ❍ ASTHMA ❍ DEPRESSION ANXIETY

❍ OTHER:____________________

Have you ever had surgery (please circle if yes):

❍ TONSILS ❍ APPENDIX ❍ WISDOM TEETH ❍ BREAST IMPLANTS ❍ CSECTION

❍ OTHER:____________________

Do you smoke? ❍ YES ❍ NO If yes how much per day? ____________________

Any present or past history of ALCOHOL or DRUG addiction/abuse? ❍ YES ❍ NO

List any medications & their doses that you are currently taking (including birth control pills):____________________

____

____

____

Please list any allergies to medications or circle: ❍ NONE

____

____

____

____

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Do you have any family history of cancer of the BREAST, UTERUS OR OVARIES? ❍ YES ❍ NO

If yes, please list who: ______________________________

What is the date of your last menstrual period or year of menopause? ______________________________

Have you ever been pregnant? (circle) ❍ YES ❍ NO If YES, how many times?______________________________

How many children do you have______________________________

Are you currently pregnant? ______________________________

What is the approximate date of your last Pap smear? ______________________________

Have you ever had an abnormal pap smear result? YES or NO If yes, when was it? ______________________________

Have you ever had a mammogram? ❍ YES ❍ NO If yes, when was it done last? ______________________________

Have you ever had a colonoscopy? ❍ YES ❍ NO If yes, when was it done last? ______________________________

Have you ever had a DEXA Bone Scan? ❍ YES ❍ NO If yes, when was it done last? ______________________________

We participate with many different insurance plans and will file primary and secondary claims for you. It is understood that the insurance policy is an agreement between the patient and the insurance company to pay certain amounts for medical care. It is you responsibility to know the details of your health insurance in regard to referrals, co-payments, and percentage of coverage.

Signature: ______________________________ DATE: ______________________________

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