Masahide Kanayama, MD

New York Endometriosis & Infertility Center
150 East 55th Street 5th Fl. NY 10022
Tel: 212-421-1016 Fax: 212-421-1019

Patient Information

Patients Name: ______________________ Gender ( ) Male ( ) Female
Address: ______________________ Apt # __________
City/State ______________ Zip __________ SS# __________
Home # __________ Work # __________ Cell # __________
Date Of Birth __________ Age ____ Marital Stat ( ) Single ( ) Married ( ) Div ( ) Wid
Employer ______________ Occupation ______________
Employers Address ______________________
How did you hear about us? ______________________

Emergency Contact Person: ______________________
Company Name: ______________ Phone # __________
Address: ______________________
Person responsible for bill, if other than self ______________________
Address: ______________ Relation __________ Phone # __________

Insurance Information

Primary Insurance Name: ______________________
Adrress: ______________________
Phone: ______________ Relation To Insured: __________
Insured Social Security # ______________________
Insured Date of Birth ______________________
Policy ID # ______________________
Group Name ______________________

Secondary Insurance Name: ______________________
Adrress: ______________________
Phone: ______________ Relation To Insured: __________
Insured Social Security # ______________________
Insured Date of Birth ______________________
Policy ID # ______________________
Group Name ______________________

I verify the accuracy of the above information and I authorize the release of any medical or other information necessary to process any claims.

Signature: ______________________ Date: __________

Method	Date Started	Length of Use	Problem
_____ birth control pills	__________	__________	__________
_____ condom	__________	__________	__________
_____diaphragm	__________	__________	__________
_____foam	__________	__________	__________
_____ IUD	__________	__________	__________
_____natural family planning	__________	__________	__________
_____other	__________	__________	__________

FAMILY HISTORY

Has any member of your immediate family had cancer, heart disease, diabetes, or genetic disease? Yes_____ No_____ If yes, explain____

____

Are there any other health problems which were not covered on this form? Yes_____ No_____

If yes, explain____

MENOPAUSAL HISTORY

Age of onset of menopause ________

Are you experiencing any menopausal symptoms? _______

Are you currently on hormone replacement therapy? _______

SURGICAL HISTORY

List all surgeries you have ever had (include C-sections, tonsillectomy, gallbladder, oral, etc.)

Date of Surgery:	Type of Surgery:
__________	____________________________________
__________	____________________________________
__________	____________________________________

To the best of my knowledge, I have answered all questions accurately.

Signature: ________________________________ Date: ____________

OB/GYN HISTORY

Name: ____________________________ Date of Birth: _____________ Date: _____________

Reason for Visit/Chief Complaint:

____

____

Primary Care Physician: ____

GYNECOLOGICAL HISTORY

Last normal menstrual period (first day) __________ Menarche (age when period began) ______

Abnormal bleeding? Yes____ No_____ Describe______________________________________

Bleeding after intercourse? Yes____ No_____ Describe_________________________________

Painful intercourse? Yes____ No_____ Describe______________________________________

Discharge? Yes____ No_____ Describe____

Infection in uterus, tubes, or ovaries? Yes______ No_____ When______ Treatment__________

Infection in vagina? Yes______ No_____ When_________ Treatment_____________________

Date of last Pap smear _______________ Results_______________ Where________________

Date of last mammogram _____________ Results ______________ Where ________________

OBSTETRICAL HISTORY

Total number of pregnancies __________

Number of living children __________

Number of miscarriages __________

Number of abortions __________

Number of stillborns __________

Date of last pregnancy __________

Are you presently using any method of contraception? Yes_____ No_____ Method __________

In the past, have you used any of the following contraceptive methods: