**MARYELLEN ROMANO, MD**
1110 South Avenue
Staten Island, NY 10314
Phone (718)761-4700
Fax (718)494-2767

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**PATIENT CONTACT INFORMATION:**

**First Name** _____ **Middle Initial**_____ **Last Name**_____

Date of Birth __/__/____ Age _____ Occupation _____

Home Street Address _____

City _____ State _____ Zip Code _____

**Please circle one of the following:**

Race: Caucasian Black Asian American Indian /Alaska Pacific Islander Declined

Ethnicity: Hispanic Non- Hispanic Declined Primary Language _____

**Please check off your preferred contact number**

{ } Home Phone ( ) _____ { } Work Phone ( )_____

{ } Cell Phone ( ) _____

Emergency Contact_____ Phone Number ( ) _____

Marital Status { } Single { } Married { } Divorced { } Widowed { } Domestic Partner

**Primary Care Physician:** Name _____

Address _____ Phone Number ( ) _____

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**GYNECOLOGIC HISTORY:**

Age at onset of periods _____ Frequency of period_____ Length of period _____

How many?
Pregnancies _____ Births _____ Miscarriages _____Terminations of pregnancy _____

Age at birth of first child _____

Method of contraception _____

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**Vaccinations**

| | | | |
|---|---|---|---|
| Gardasil | { } Yes | { } No | Date Administered __/__/____ |
| Pneumovax | { } Yes | { } No | Date Administered __/__/____ |
| Influenza | { } Yes | { } No | Date Administered __/__/____ |

| **What was the date of your last?** | | Please Circle one of the following |
|---|---|---|
| Pap smear | __/__/___ | Negative/ Abnormal |
| Mammogram | __/__/___ | Negative/ Abnormal |
| Colonoscopy | __/__/___ | Negative/ Abnormal |
| Bone Density | __/__/___ | Negative/ Abnormal |

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**MEDICAL HISTORY:** Do you have any medical problems? { }No { } Yes – Please List

(1)_____
(2)_____
(3)_____
(4)_____
(5)_____
(6)_____

**Please list your Current Medications / Vitamins and dosages**

_____ _____
_____ _____
_____ _____
_____ _____

**Do you have any Allergies to medications or foods?** { }No { } Yes – If yes please list

_____ _____
_____ _____
_____ _____
_____ _____

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**SURGICAL HISTORY:** Have you ever had surgery? { } No { } Yes – List below in order

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| Year | Surgery and Reason and any Complications |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**SOCIAL HISTORY:**

| | | |
|---|---|---|
| Do you wear seatbelts? | { } Yes { } No | If No, why not? _____ |
| Do you exercise regularly? | { } Yes { } No | If YES, type, duration and number of times per week?_____ |
| Do you smoke? | { } Yes { } No | If YES how many packs per day? _____ |
| Do you drink alcoholic beverages? | { } Yes { } No | If YES how much per week? _____ |
| Do you drink tea? | { } Yes { } No | If YES how many cups per day? _____ |
| Do you drink coffee? | { } Yes { } No | If YES how many cups per day? _____ |
| Do you have a gun in your home? | { } Yes { } No | { } N/A |
| If there is a gun in your home, do you keep it unloaded and out of children's reach? | { } Yes { } No | { } N/A |
| Do you use drugs? | { } Yes { } No | If YES explain _____ |
| Have you ever engaged in any activity which has put you at risk of getting HIV? | { } Yes { } No | If YES explain _____ |
| Do you wish to be tested for HIV? | { } Yes { } No | |
| Have you ever worked with hazardous materials? | { } Yes { } No | If YES explain _____ |
| Are you in a relationship in which you have been physically hurt by your partner? | { } Yes { } No | |
| Do you ever feel afraid of your partner? | { } Yes { } No | |
| Do you have a living will? | { } Yes { } No | |
| Do you have a donor card? | { } Yes { } No | |

**FAMILY HISTORY:** Has any member of your family ever had Cancer? { } No { } Yes – If yes please list

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| Type of Cancer | Age when diagnosed | Relationship to You |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PATIENT'S SIGNATURE** _____ **DATE** _____

**I confirm that I have reviewed the above information.**

**PHYSICIAN'S SIGNATURE** _____ **DATE** _____