Sarah Fletcher, MD
Cynthia Yew, FNP-BC
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Maria Young, FNP-C

21135 Whitfield Place Suite 107
Sterling, VA 20165
Phone: (703) 421-7000
Fax: (703) 430-4830

www.sterlingfamilypractice.com

PATIENT INFORMATION

LAST NAME		**FIRST NAME**	MIDDLE INITIAL
SOCIAL SECURITY NUMBER		SEX Male Female	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*		STATUS *(please check one)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner	STUDENT *(please check one)* ☐ No ☐ Full Time ☐ Part Time
STREET ADDRESS		CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*		WORK PHONE	CELL PHONE
RACE *(please check one)* ☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other Race American ☐ Indian/Alaska Native		ETHNICITY *(please check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	PREFERRED LANGUAGE *(please check one)* ☐ English ☐ Spanish ☐ Other: ________________________
EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
EMAIL ADDRESS			
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(please check one)* ☐ Cell Phone ☐ Home Phone			

CONTACT (Guarantor information section below must be filled if you are not making payment for SFP visits)

CONTACT *(please check at least one)* ☐ Emergency Contact ☐ Guarantor ☐ Next of Kin ☐ A uthorized to Seek Treatment ☐ Insured		LAST NAME	FIRST NAME		MIDDLE INITIAL
SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS	
HOME ADDRESS		CITY/STATE	ZIP CODE	CELL PHONE	HOME PHONE
EMPLOYER		WORK NUMBER		JOB TITLE	

Guarantor information section must be filled if: (The guarantor is the person responsible for payment incurred by SFP)

CONTACT *(please check at least one)* **Guarantor** ☐ Emergency Contact ☐ Self guarantor ☐ Other Guarantor ☐ Insured ☐ Authorized to Seek Treatment ☐ Next of Kin		LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
HOME ADDRESS		CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER		WORK PHONE	JOB TITLE	

Over →

INSURANCE POLICY INFORMATION

POLICY NUMBER	**GROUP ID**			EFFECTIVE DATE
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE		COPAYMENT AMOUNT Office: $________ Specialist: $_________
NAME OF INSURANCE COMPANY/PLAN	**INSURANCE COMPANY ADDRESS**			PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE	
INSURED'S MAILING ADDRESS		PRIMARY CARE PHYSICIAN (PCP) &/OR REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID			EFFECTIVE DATE
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE		COPAYMENT AMOUNT Office: $________ Specialist: $_________
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS			PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE	

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to SFP or any of its affiliates or agents, lenders, or any third party servicer acting for SFP or any of its affiliates. I also authorize SFP to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

____ ___________________

Print Name Date

____

Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

SFP is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any SFP health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a SFP health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from SFP or until I withdraw it.

____ ___________________

Signature of Patient, Parent/Legal Guardian Date

____

Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

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Office Policies

Billing

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable co-pay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. If you do not have your insurance information available at the time of your visit, we require that you pay 100% of charges rendered prior to the visit. If you have an outstanding balance due, we appreciate the prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due over to a collection agency. In addition to the principle balance due, you will also be responsible for any legal or collection agency fees incurred. Any payment made to us in the form of a check that is returned for insufficient funds will incur a $25.00 fee per incidence.

Cancellations

Cancellations We will attempt to contact you to remind you of your appointment 48 hours prior to your appointment. If you are unable to keep your appointment, we require a 24 hour notice of cancellation. If you fail to show for your appointment without notifying us, we reserve the right to charge you a $50.00 "no show" fee for 1st no show and $100.00 fee per no show thereafter.

Prescription Refills

We request 72 hours to refill prescriptions from time of request. **The best way to request refills is to call your pharmacy two (2) weeks before your medication runs out and your pharmacy will contact Sterling Family Practice.**

Referrals/Prior Authorizations

Please call your insurance to verify if a referral/prior authorization is needed. **Some insurance companies do not require a referral. Please allow at least 72 hours to obtain your referral.** Some insurance's can take up to 7 business days to receive approval or denial. We cannot back date referrals and we cannot accommodate same day referrals unless it is a true emergency.

By signing this form, I have agreed to the terms and conditions listed above.

______________________________	____________	____________
Printed Patient Name	Date of Birth	Today's Date

____
Patient Signature

______________________________	______________________________
Printed Name of Personal Representative	Relationship to Patient

____
Signature of Personal Representative

Thank you for choosing Sterling Family Practice as your primary care provider.

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Sterling Family Practice
Receipt of Notice of Privacy Practices Acknowledgement

____
Patient's Name

I have a received a copy of Sterling Family Practice's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

____
Signature

Date:____

____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**

Sterling Family Practice
NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or comments about this Notice please contact:

Sterling Family Practice
21135 Whitfield Place Ste 107
Sterling, VA 20165
Compliance officer: Alex Salgado

Who Does this Notice Apply to?

Sterling Family Practice , has published this Notice. It applies to everyone who works for Sterling Family Practice including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

SFP understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from ______________ until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment***. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment***. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in

connection with payment for your care.

- ***Health care operations***. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.

- In case of suspected child abuse, to the appropriate governmental authority.

- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.

- Unless you object, to friends or family members who are involved in your medical care.

- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.

- To health oversight authorities, for regulatory, licensing and other legal purposes.

- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.

- To law enforcement agencies, subject to applicable legal requirements and limitations.

- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

- To Funeral Directors/Medical Examiners/Coroners in the event of your death.

- When required by Federal, State or Local law.

- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.

- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appoint-ments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, SFP would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support

the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for SFP;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with SFP, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.

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Permission to Disclose Information

I, ____, acknowledge that I was made aware of the Sterling Family
(print patient name)

Practice Privacy Policy and a copy was made available to me for my review.

I authorize Sterling Family Practice to disclose my protected health information to the following person(s) and entities:

Name	Date of Birth	Relationship to You

____
Printed Patient Name

____
Today's Date

____
Patient Signature

____
Printed Name of Personal Representative

____
Relationship to Patient

____
Signature of Personal Representative

Notification of Test Results

In most cases, you will be notified by mail of your test results. Please ensure the address we have on file for you is correct.

Preferred phone number: ____

May we leave a detailed message at this number? ☐ Yes ☐ No

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Please take a moment to fill out this medical history form so that your practitioner can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

Patient's Full Name: ______________________ Date of Birth: ______________

Today's Date: __________ Height: ________ Weight: _________ Blood Type: ☐ A ☐ B ☐ AB ☐ O+ ☐- O

Primary Care Doctor: ______________ Referring Doctor: ______________________

Reason for Visit: ____

Preferred Pharmacy Name: ____________ Pharmacy Address: ____________________

Pharmacy Phone Number: __________________ Pharmacy Fax Number: ______________

Allergies: (List all medications, food and environmental)

____

____

Medications: (List all current medications including vitamins & supplements)

Date started	*Medication & Dose*	*Directions*	*Reason for Taking*	*Prescribed by*

Past Medical History: (Please check all that apply)

☐ Attention Deficit Disorder	☐ Dizziness/Vertigo	☐ Headache	☐ Leukemia
☐ Anemia	☐ Depression	☐ Herpes	☐ Migraine Headache
☐ Asthma	☐ Easy Bleeding	☐ HIV Infection	☐ Osteoporosis
☐ Alcohol Disorder	☐ Eczema	☐ Heart Disease	☐ Pneumonia
☐ Bronchitis	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Back Problems	☐ Esophageal Reflux	☐ Hodgkin's Disease	☐ Seizure Disorder
☐ Cancer	☐ Fatigue	☐ Insomnia	☐ Sleep Apnea
☐ Concussion	☐ Gastrointestinal Disorder	☐ Lupus	☐ Stroke Syndrome
☐ Diabetes Mellitus	☐ Glaucoma	☐ Lyme Disease	☐ Thyroid Disorder

Please list any other past medical history:

____

____

Past Surgical History: (Please check all that apply and include the date)

Surgery	*Date*	*Surgery*	*Date*	*Surgery*	*Date*
☐ Appendectomy		☐ Hernia Repair		☐ Shoulder Surgery	
☐ Back Surgery		☐ Hysterectomy		☐ Sinus Surgery	
☐ Breast Surgery		☐ Hip Surgery		☐ Tonsillectomy	
☐ Cataract Surgery		☐ Knee Surgery		☐ Thyroid Surgery	
☐ C-Section		☐ Laparoscopy		☐ Vasectomy	
☐ Colonoscopy		☐ Pacemaker Placement		☐ Wisdom Teeth	
☐ Cosmetic Surgery		☐ Prostate Surgery		☐ Other: _________	

Family History: (Please check all that apply)

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Alcoholism								
Asthma								
Bleeding disorder								
Cancer								
Deceased								
Depression								
Diabetes								
Drug Abuse								
Epilepsy								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Migraines								
Stroke								
Suicide								
Thyroid Problems								

Please list any other family medical history:

____

____

Prevention Information:

	Yes	*No*		*Yes*	*No*
Do you use seat belts?			Do you have a living will?		
Do you have smoke detectors in your home?			Do you practice a healthy diet?		
Do you have a loaded firearm in your home? If yes, how is it stored?					
Do you use sunscreen?					

Please list any vaccine history:

____

____

Social/Lifestyle History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

If married, spouse's name: ____

Children(s) names and age(s): ____

What is your occupation: ____

What are your hobbies: ____

Do you exercise regularly: ____

Who lives at home with you: ____

Where were you born and raised: ____

How long have you been in this area: ____

Do you drive an automobile: ____________________Do you ride a motorcycle/bicycle: ________________

Do you wear a helmet: ____

Do you currently smoke or use nicotine products: ____________ If yes, for how many years: ________________

Are you a former smoker: ________________________________ If yes, when did you quit: _________________

Cigarettes (# Packs/day): ______ Cigars: ______ Pipe: ______ Chew Tobacco: _____________________

Have you ever used recreational drugs: ______ If yes, when was the last time: ____________________________

What kind did you use: ____

Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products: _______________

If yes, which ones and how often: ____

Do you take something to help you sleep: _______________ If yes, what and how often: ___________________

Do you restrict your diet in any way: ___________________ If yes, how: ________________________________

Do you drink alcohol: ☐ Never ☐ Occasionally ☐ Daily

If yes, how many days per week do you drink alcohol: ____

On a typical day when you drink, how many drinks do you have: ________________________________

Do you drink caffeine: ______________ If yes, how much: ____

Ever worked with chemicals, paints, asbestos, or any hazardous material?: _______________________________

If yes, what kind: ____

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Review of Symptoms

Patient's Full Name: ____________________ Date of Birth: ________Today's Date: ______________

Please check all that apply.

☐ Male ☐ Female Medication allergies: ☐ Yes ☐ No

Please check any symptoms you are experiencing today.

Systemic Symptoms	☐ fatigue ☐ fever/chills ☐ weight change
Head Related	☐ headache ☐ facial pain
Eye	☐ trouble with vision ☐ pain ☐ redness ☐ light sensitivity
Ear-Nose-Throat-Mouth	☐ earache ☐ pressure ☐ ringing ☐ TMJ ☐ runny nose ☐ nose bleeds ☐ post nasal drip ☐ sneezing ☐ snoring ☐ sore throat ☐ itchy throat ☐ hoarseness ☐ mouth sores ☐ dryness ☐ trouble swallowing
Neck	☐ swollen glands ☐ pain ☐ muscle tightness
Respiratory	☐ cough ☐ wheezing ☐ shortness of breath
Cardiovascular	☐ chest pain ☐ palpitations ☐ irregular heart rate ☐ edema ☐ fast heart rate
Gastrointestinal	☐ abdominal pain ☐ heart burn ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ blood in stool ☐ change of bowel habits
Urinary	☐ pain ☐ frequency ☐ blood in urine
Skin	☐ rash ☐ lesions ☐ abnormal hair loss
Musculoskeletal	☐ joint pain ☐ back pain ☐ muscle pain ☐ restless legs
Neurological	☐ fainting ☐ numbness ☐ dizziness
Psychological	☐ insomnia ☐ depression ☐ anxious ☐ irritable ☐ generally not having fun in life
Male	☐ slow urine flow ☐ low libido ☐ erectile dysfunction
Female	☐ pelvic pain ☐ PMS ☐ vaginal discharge ☐ abnormal bleeding Date of last period: ________________________ Date of last pap: __________________ Period last _____ days Period comes every ______days # of pregnancies ___________ # of births ______________ Current method of birth control ____________________________________
Date of last tetanus shot	

Other additional comments:

____

____