STEFANIE MIKULICS, M.D.

Name: _____ **Today's date:** _____

Email Address: _____ **Home Number #:** _____

Mobile Phone #: _____ **Work Phone #:** _____

Current Mailing Address

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

What brings you in to see us today? _____

What Medications are you currently taking (including herbal supplements, topicals, botanicals and vitamins)?

_____

_____

What day did your last period start? _____ **N/A (Menopause & or Hysterectomy)**

Any Allergies to medications? _____

_____

Any updates or changes to your family, medical or social history? _____

_____

Have you had any hospitalizations, surgeries, or a new medical diagnosis since your last visit?

_____

Who is your primary physician? _____

Are you experiencing any of the following?

Difficulty losing weight	Nipple Discharge	Bleeding between Periods	Interest in Cosmetic treatments (Botox, fillers, skin resurfacing)
Interest in permanent fat reduction	Pelvic Pain	Vaginal Discharge	
Vision Problems	Pain with Urination	Vaginal Discomfort	Other
Headaches	Leaking of Urine	Skin Rash	
Dizziness	Blood in Urine	Joint Pain	
Cough	Increased Frequency of Urination	Muscle Weakness	
Chest pain	Diarrhea/Constipation	Depression/Sadness	
Shortness of Breath	Blood in Stool/Black Stool	Anxiety	
Heartburn	Hemorrhoids	Insomnia	
Abdominal Pain	Vaginal Dryness	Hot Flashes	
Nausea/Vomiting	Pain with Sex	Night Sweats	
Breast Tenderness	Bleeding with Sex	Fever	
Breast Lump	Heavy Periods	Is anyone hurting you?	

Any other Problems or Comments?

Thank You very much for your patience. Your answers are very important to us. ☺