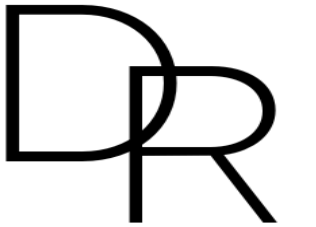

Donna Robey, MD
2500 N 14TH STREET
SAINT LOUIS, MO 63106
(3 1 4) 6 9 7 - 4 8 1 5
DONNAROBEYMD.NET

Name (first, M.I.,last): _____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Gender:_____ Ethnicity:_____

Pharmacy and Location: _____

Home Phone #:_____ ☐ Ok to Leave a Detailed Message

Cell Phone #: _____ ☐ Ok to Leave a Detailed Message

Work Phone #: _____ ☐ Ok to Leave a Detailed Message

Insurance Information

Primary Insurance:_____ Policy Holder:_____

Relationship to Patient:_____ D.O.B._____ ID #:_____ Group:_____

Secondary Insurance:_____ Policy Holder: _____

Relationship to Patient:_____ D.O.B._____ ID #:_____ Group:_____

I authorize my insurance benefits to be paid directly to Donna Ann Robey, MD, LLC. I understand that I am financially responsible for any services not covered by my insurance, as verified by the information above

Emergency Contact Information

Name:_____ Number:_____ Relationship:_____

Name:_____ Number:_____ Relationship:_____

Person(s) who we may discuss your health information with

Please be aware that you are authorizing Donna Ann Robey, MD, LLC to discuss your health information with the person(s) listed below, and that if any time those person(s) should change it is your responsibility to inform Donna Ann Robey, MD, LLC.

Name:_____ Number:_____ Relationship:_____

Name:_____ Number:_____ Relationship:_____

Health History

Please Check All Of Your Current and Past Medical Conditions

☐ ADHD	☐ Eczema	☐ Seizures
☐ AIDS/HIV	☐ Glaucoma	☐ Stroke
☐ Allergies	☐ Gout	☐ Transfusions
☐ Anemia	☐ Heart Disease	☐ Thyroid Disease
☐ Arthritis	☐ Hemorrhoids	☐ Ulcers
☐ Asthma	☐ Hepatitis	☐ Venereal Disease
☐ Bladder Infections	☐ High Blood Pressure	☐ Other:
☐ Bronchitis	☐ High Cholesterol	☐ Other:
☐ Cancer	☐ Kidney Disease/Stones	☐ Other:
☐ COPD	☐ Mental Illness (anxiety,depression, bipolar)	☐ Other:
☐ Diabetes	☐ Migraines	☐ Other:
☐ DVT	☐ Osteopenia/Osteoporosis	☐ Other:

Please list all serious illnesses, operations and other hospitalizations

_____ _____

_____ _____

_____ _____

List Current Medications	Dose/MG	Directions

Allergies :

(Medications, food, and/or environment and reaction)

_____

_____

Social History

Tobacco Use: (Cigars, cigarettes, vape, etc.) No/Yes Per Week:_____ Years:_____ Former:_____

Alcohol: # per_____ Other Substance Use:_____ Exercise_____

Occupation:_____ Hobbies:_____

Preventive Care

Gardasil/HPV Vaccine:_____ Flu Vaccine:_____

Bone Density Test:_____ Pelvic Exam:_____

Last Mammogram: _____ Last Colonoscopy:_____

Family History

If any blood relative has had any of the following, **please list who**

☐ Alcoholism:	☐ Diabetes:	☐ Liver Disease:
☐ Allergies:	☐ Drug Problems:	☐ Mental Illness:
☐ Alzheimer's/Dementia:	☐ Glaucoma:	☐ Migraine Headache:
☐ Arthritis:	☐ Gout:	☐ Obesity:
☐ Asthma:	☐ Hearing Deficiency:	☐ Osteoporosis:
☐ Bleeding Tendency:	☐ Heart Disease:	☐ Parkinson's Disease:
☐ Cancer(Type):	☐ High Blood Pressure:	☐ Seizure
☐ COPD	☐ High Cholesterol	☐ Stroke:
☐ Crohn's Disease	☐ Kidney Disease/Stones:	☐ Thyroid Disease:

By my signature, I verify that the information I provided is correct to the best of my knowledge.

Patient/Guardian Signature:_____ Date:_____