OB·GYN
ASSOCIATES OF WNY

Account #_____

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PATIENT REGISTRATION

PATIENT INFORMATION:

Name:_____ Date of Birth: _____

Social Security #_____ Email Address:_____

Mailing Address:_____ City/Zip Code:_____

Home Phone:_____ Cell Phone:_____

Preferred Phone: Home ☐ Cell ☐

Primary Care Physician:_____ Referring Physician:_____

Emergency Contact:_____ Daytime Phone: _____

How Did You Hear About Us? Phone Book ☐ Web ☐ Newspaper ☐ Family/Friends ☐ Other ☐ _____

INSURANCE INFORMATION:

Co-Pay:_____(Required at Check-In) Primary Insurance: _____

ID#_____ Group #_____ Employer: _____

Policy Holder: _____ Relationship: _____ DOB:_____

Secondary Insurance: _____

ID#_____ Group #_____ Employer: _____

Policy Holder: _____ Relationship: _____ DOB:_____

RESPONSIBLE PARTY INFORMATION: **(For Patients Under 18 Only)**

Name: _____ Relationship: _____ DOB:_____

Mailing Address: _____ City/Zip Code: _____

INFERTILITY PATIENT INFORMATION:

Male Donor Name:_____ Relationship: _____ DOB:_____

Insurance Carrier: _____ ID# _____

Account #_____

Date: _____

Name: _____ Primary Pharmacy: _____

Primary Care Physician: _____ Secondary Pharmacy: _____

Referred By: _____ Mail Order Pharmacy: _____

Date of Birth: _____ Race: _____ Ethnicity: _____

Primary Language: _____

Gender Identity: ☐Female ☐Male ☐Nonbinary ☐Choose not to disclose
Preferred Pronoun_____ Other_____

Briefly state the reason for your visit today:

_____
_____

Other Physicians you currently see

Physician	Specialty	Date last seen

Current Medications (please include Vitamins/Herbal supplements) Additional medication write on back

Name	Dosage	Prescriber

Drug Allergies: ☐No known drug allergies

Drug Name	Reaction

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Well Woman Update

Age of first menstrual period: _____ If menopausal, age of menopause: _____

First day of your last menstrual period: _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days.

Are your cycles: ☐Regular? ☐ Irregular if so how? _____

Are you sexually active? ☐ Never ☐Not currently ☐ Yes

With: ☐Men ☐Women ☐ Both

Number of lifetime sexual partners: _____

Well Woman Update (cont.)

Last Bone Density Date: _____ Result: _____

Last Colonoscopy Date: _____ Result: _____

Last Mammogram Date: _____ Result: _____

Last Pap Smear Date: _____ Result: _____

Any abnormal Pap Smears? ☐Yes ☐ No

If yes, any treatment?

Colposcopy date: _____ LEEP Date: _____ Cryotherapy (freezing) Date: _____

Colposcopy Result: _____ LEEP/cold knife cone Result: _____

HPV/Gardasil Vaccine Series completed? ☐Yes ☐ No

Have you had the Hepatitis B series? ☐Yes ☐No

Method of contraception:

☐ Not needed ☐Vasectomy ☐Tubal Ligation ☐Condoms ☐NuvaRing

☐ None ☐Pill ☐Patch ☐Depo Provera

☐IUD (type & date inserted) _____

☐ Nexplanon (date inserted) _____ ☐Right Arm ☐ Left Arm

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Obstetrical History

Please list all pregnancies, **including** miscarriages, abortions, chemical, and ectopic pregnancies. First line is an example to follow. Write any additional pregnancies on back.

Have you been tested for Cystic Fibrosis? If so where and when: _____

Delivery Date	Weeks	Length of Labor (hours)	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications
1/15/75	40	12	6Lb.2oz	F	Vaginal	Epidural	High Blood pressure

Medical History

Have you had chicken pox? ☐Yes ☐ No If no, were you vaccinated? ☐Yes ☐No ☐Unsure

Do you know your blood type? ☐Yes ☐No If yes, what type: _____

Do you now have or have ever been diagnosed with?

☐ Asthma ☐ Auto Immune Disorder Type: _____ ☐Bleeding Disorder Type: _____ ☐ Bone/Joint Disease ☐ Cancer Type: _____ ☐ Deep Vein Thrombosis ☐ Depression ☐Diabetes Type: _____	☐ High Cholesterol ☐ Endometriosis ☐ Fibroids Type: _____ ☐ Heart Disease ☐Hepatitis Type: _____ ☐ Herpes Type: _____ ☐ HIV ☐ HPV	☐ High blood Pressure ☐ Infertility ☐ Liver Disease ☐ Migraines ☐ Migraines with Aura ☐Osteopenia ☐ Osteoporosis ☐ Pulmonary Embolism ☐ Seizure Disorder ☐ Syphilis ☐ Thyroid Disease Not Listed: _____ _____ _____

Account #_____

Surgical History: (Please list **ALL** surgical procedures, including year and surgeon)

_____
_____
_____
_____

Please list any non-surgical hospitalizations: (dates and reasons)

_____
_____
_____

Family History

Has anyone in your immediate family been diagnosed with the following. If so who, age of diagnosis, stage and treatment.

Breast Cancer: _____

Colon Cancer: _____

Ovarian Cancer: _____

Uterine Cancer: _____

	Age:	**Any Major Illness:**	**If deceased, cause of death:**
Mother			
Father			
Brother			
Sister			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Aunts/Uncles			

Account #_____

Social History

Highest Level of education completed: _____

Are you?

☐ Married ☐Engaged ☐ In a relationship ☐ Single ☐ Legally Separated ☐ Divorced ☐ Widowed

Partner's name and gender: _____

Work Status: ☐ Full Time ☐ Part time ☐Disabled ☐Retired ☐Unemployed ☐Homemaker

Occupation: _____

Tobacco Use: ☐ Never ☐ Current _____# of Cigarettes per day ☐ Former, Quit at age _____

Do you use another form of nicotine (i.e.: vape) ☐ Yes ☐ No *if yes what? _____

Alcohol use? ☐ Yes ☐ No *If yes, the average number of drinks per week_____

Do you use street drugs? ☐Yes ☐ No *If yes, the type used and last use_____

Have you ever been diagnosed with any of the following?

Herpes (Type 1 or 2/ oral or genital): _____

Gonorrhea☐ Chlamydia☐ Trichomoniasis☐ HPV☐

Religion: _____ Exercise: _____

Hours of sleep: _____ Hobbies: _____

Special Diet: _____ Coffee: _____

Recent travel outside USA: _____