



Account # _____

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PATIENT REGISTRATION

PATIENT INFORMATION:

Name: _____ Date of Birth: ____/____/____
Preferred Name: _____

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
EXAMPLE 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?

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

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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: Yes ☐ No ☐ If yes, cups per day _____

Recent travel outside USA: _____