OB/GYN Care of WNY

CARLOS SANTOS, MD CARMEN TODORO, MD BRIAN SMITH, MD
JEFFREY CONSTANTINE, MD AFSHAN SAMAD, MD JENNIFER ROJEK, MD
JAY BOLNICK, MD AMBER KROL, DO ALAN BOLNICK, MD LEENA KULKARNI, MD

3050 Orchard Park Rd.
West Seneca, NY 14224
Phone: (716) 766-5222
Fax: (716) 675-9329

4845 Transit Rd.
Depew, NY 14043
Phone: (716) 766-5222
Fax: (716) 656-2204

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# _____

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

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

Obstetrical History

Please list all pregnancies, **<u>including</u>** 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?

☐ 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:

		_____ _____ _____

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			

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: _____