BENNY ESQUENAZI, M.D.
Advanced Female Care - OB /GYN

HOURS
Monday - Friday
9 am - 5 pm

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PATIENT REGISTRATION - 1 PAGE

1. PATIENT INFORMATION & INSURANCE FORM

Name _____ DOB _____

Street Address _____ City _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell ( ) _____

Your Pharmacy _____ Email _____

Date of Birth _____ Social Security Number _____

Employer _____ Occupation _____

Referred by _____

Mother & Father's First Names _____ (for identification only) _____

2. INFORMATION REGARDING SPOUSE AND /OR EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone Work Phone ( ) _____ Cell ( ) _____

3. INSURANCE INFORMATION - Please have your insurance card with you and present it to front desk with this form.

Primary Insurance

Insurance Carrier _____ ID# _____

Insured Party _____ Relationship to Patient _____

Insured Parties DOB _____

Secondary Insurance

Insurance Carrier _____ ID# _____

Insured Party _____ Relationship to Patient _____

Insured Parties DOB _____

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PATIENT REGISTRATION - 2 PAGE

3.1. PATIENT MEDICAL HISTORY FORM

Name _____ DOB _____

1) Date Of Last Menstrual Period _____

2) Date of Last Mammogram _____ Date to Last Bone Density _____

Date of Last Colonoscopy _____ Date to Last Colposcopy _____

Date of Last Breast Ultrasound _____ Date to Last Pelvic Sono _____

3) Do you have any medical problems? Check all that apply.

☐ ASTHMA/LUNG DISEASE	☐ ANEMIA	☐ OSTEOPOROSIS/PENIA
☐ ARTHTITIS	☐ ALLERGIES	☐ STROKE
☐ ANXIETY	☐ COLON CANCER	☐ BLEEDING DISORDERS
☐ BREAST CANCER	☐ CHOLESTEROL	☐ IMMUNE DEFICIENCY
☐ COLITIS	☐ DIABETES	☐ DEPRESSION
☐ BLOOD CLOTS	☐ EMPHYSEMA	☐ FIBROMALGIA
☐ HEART ATTACK	☐ HEPATITIS	☐ IDNEY DISEASE
☐ HYPERTENSION	☐ MIGRAINE	☐ MULTIPLE SCLEROISIS
☐ MITRAL VALVE PROLAPSE	☐ THYROID DISEASE	☐ IRRITABLE BOWEL SYNDROME
☐ REFLUX/GASTRITIS	☐ RHEUMATOID DISEASE	☐ STOMACH ULCERS
☐ SEIZURES	☐ MENTAL HEALTH ISSUE: _____	

Please list any Medical Problems you have that are not listed above:

_____

_____

_____

4. Do you have any gynecological problems or conditions? Check all that apply.

☐ Abnormal Paps, If so any treatment? _____

☐ DES Exposure	☐ Painful Intercourse	☐ Ectopic Pregnancy
☐ Endometriosis	☐ Heavy, Painful Periods	☐ Fibroids

STDs: ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Herpes

☐ PMS ☐ Irregular Cycles

☐ Infertility, If so for what reason? _____

PATIENT REGISTRATION - 3 PAGE

☐ Ovarian Cysts ☐ Pelvic Inflammatory Disease

Cancer of: ☐ Breast ☐ Ovary ☐ Uterus ☐ Cervix

☐ Recurrent Miscarriages ☐ Urinary frequency or accidental loss of urine

☐ Contraception Type of Contraception _____

IUD Type and insertion date (if applicable) _____

5. Please list any allergies to medications and/or latex.

6.OBSTETRIC HISTORY

How many pregnancies have you had? _____

Year of Birth Number of Weeks	Hospital	Full Term/ Pre Term	Vaginal, Forceps, Vacuum or Cesarean	Birth Weight	Sex of Child

Please list any miscarriages of abortions.

Year	# of Weeks Pregnant	D&C or not

Any complications during pregnancy or childbirth?

_____

_____

PATIENT REGISTRATION - 4 PAGE

7. PLEASE CHECK ALL PREVIOUS SURGERIES INCLUDING GYNECOLOGIC SURGERIES LISTED BELOW.

☐ D&C Removal of ovary: ☐ Right ☐ Left ☐ Both

☐ Hysterectomy ☐ Myomectomy

☐ Tubal Ligation ☐ Endometrial Ablation

☐ Cryosurgery ☐ LEEP of Cervix

☐ Bladder Prolapsed ☐ Laparoscopy for: _____

☐ Breast Surgery ☐ Cesarean Section

Year Performed	Type of Surgery	Reason for Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING.

_____

_____

_____

9. FAMILY HISTORY: ARE THERE AY DISEASE THAT RUN IN THE FAMILY?

Please mark below which family members have a particular disease. Please abbreviate M for mother, F for father, and S for sibling. For extended family please mark M for maternal or P for Paternal (for example MG for Maternal Grandmother).☐

☐ DIABETES _____ ☐ HEART DISEASE _____

☐ OVARIAN CANCER _____ ☐ BREAST CANCER _____

☐ UTERINE CANCER _____ ☐ COLON CANCER _____

☐ HIGH BLOOD PRESSURE _____

PATIENT REGISTRATION - 5 PAGE

For Obstetrical patients only:

Is there anyone on your side or your husband's side of the family with the following?

(Please write each family member and the condition).

Genetic Diseases _____

Birth Defects _____

Mental Retardation _____

10. Do you have any of the following habits?

SMOKING: packs/week _____ how many years _____

ALCOHOL: drinks/week _____

DRUGS: What kind _____ how often? _____

What kind _____ how often? _____

What kind _____ how often? _____

11. Type of employment?

_____

_____

_____

_____

_____

_____