# PATIENT REGISTRATION FORM OB GYN

**PATIENT INFORMATION** (Please print)

Patient's Legal Name: (Last)______________________________(First)____________________________________(MI) ________________________

Preferred Full Name (if different from above): ________________________________

Address: ____________________________________________________________________________________________________

City, State, Zip: ________________________________________________________________________________________________

Home Phone Number (landline):______ ______________Cell:______________________________Work: ______________________________

E-Mail Address:__________________________________________________________________Date of Birth: ______________________________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed __________________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed __________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

**Preferred** Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_______

Patient Social Security Number:____-________-_________

**RESPONSIBLE PARTY INFORMATION (*If not self*)** (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)__________________________________(First)__________________________________(MI) __________________

Date of birth: MM_______/DD______/YYYY_______ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_____-______-______Phone number: _________________

Address:______________________________________________________________________________________________________

City, State:_____________________________________ZIP: _______________________

**INSURANCE INFORMATION:** Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

**EMERGENCY CONTACT INFORMATION**

Emergency contact name: (Last)_______________________________________________ (First) ________________________________________

Phone number:____________________________________________________________________ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:___________________________________________________________ ☐ Guardian

Address______________________________________________________________________________________________________

City, State:_____________________________________ZIP: _______________________

Home phone:____________________________________Work hone:_____________________Ext. ________

**GENERAL CONSENT FOR CARE AND TREATMENT CONSENT**

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:__________________________________Date: __________________________________________

Printed name of patient or personal representative:________________________________Relationship to patient: ___________________________

# GYNECOLOGIC HISTORY QUESTIONNAIRE

Name:________________________________________ DOB: _________________ Date: _________________

Chief reason for today's visit: ___________________________________________________________________

First day of last menstrual period: ______________________________________________________________

Date of last pap smear: ____________________________Results: ____________________________________

Type of birth control currently using: ________________________________________________________
(including vasectomy, tubal ligation, condoms, abstinence, or natural family planning methods)

Are you happy with this method of birth control? _________________________________________________

Were you referred to our office? If so please tell us by who._________________________________________

## OBSTETRICAL HISTORY

Are you currently pregnant? **Y N** If so, on what date was first positive pregnancy test? _________________

Total number of times pregnant (include miscarriages and abortions): ________________________________

Total number of live births (include dates and type of delivery): ______________________________________

_________________________________________________________________________________________

Total number miscarriages: ____________________ Total number abortions: __________________________

Any complications during your pregnancies? If so, please explain: ___________________________________

_________________________________________________________________________________________

Did you have a Caesarean Section? If so, when: ___________________________________________________

Any family history of inherited disorders (i.e. Tay Sachs, Spina Bifida, Down Syndrome, other genetic disorder)?

_________________________________________________________________________________________

## GYNECOLOGICAL HISTORY

Age at first period: ______________ How many days do your periods last? _____________________________

How often do your periods come? ◻ Every 28-30 days ◻ More frequently ◻ Less frequently

How heavy is your menstrual flow? ◻ Light ◻ Moderate ◻ Heavy ◻ Extremely Heavy

Do you have bad cramps? **Y N** Do you have any PMS symptoms? **Y N**

Any bleeding between periods? **Y N** Any bleeding after intercourse? **Y N**

Any problems with urination (loss of urine while coughing, sneezing, etc.)? **Y N**

Check any of the following problems that you have had either in the past or currently:

◻ Gonorrhea ◻ Pelvic Inflammatory Disease (PID) ◻ Herpes ◻ Vaginal Infections

◻ History of physical or sexual abuse ◻ IUD Related problems

◻ Abnormal pap smears (what abnormality and when)? ________________________________________________

**MEDICAL HISTORY**

How is your health in general? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke? **Y** **N** How much? _______packs per day How many years have you smoked?______

Are you a past smoker? **Y** **N** When did you quit? _________ How many years did you smoke? ______

Do you drink alcohol? **Y** **N** How many alcoholic beverages do you have in a week? _________

Social drug use? **Y** **N** If so, what type of drugs do you use? ___________________________________

Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when? _______________________________________________________________________________________

_______________________________________________________________________________________________

Have you ever been hospitalized for a medical illness? If so, please explain: _____________________________

_______________________________________________________________________________________________

What surgeries have you had? (please give year of surgery, including cosmetic): _________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Do you have any allergies to medications? **Y** **N** Do you have any other allergies? **Y** **N**

Please List: ___________________________________ Please list: ____________________________________

___________________________________ ____________________________________

___________________________________ ____________________________________

Do you have any history of a bleeding disorder? **Y** **N** Had a blood transfusion? **Y** **N**

Do you use medication on a regular basis? Please list name and dose of medication: ______________________

_______________________________________________________________________________________________

Have you had a mammogram? **Y** **N** Date & result of last mammogram: ____________________________

Do you have any problems with your breasts? (lumps, discharge, or pain)? ______________________________

**FAMILY HISTORY** (Please check if anyone in your family has any of these conditions and tell us who has it)

☐ Breast Cancer ☐ Uterine Cancer ☐ Ovarian Cancer ☐Colon Cancer

☐ Diabetes ☐ Heart disease ☐ High Blood Pressure ☐ Stroke

☐ Osteoporosis ☐ Thyroid disease ☐ Autoimmune ☐ Other

**SOCIAL HISTORY**

Marital status: **M** **S** **D** **W** **P** Sexual Orientation? **Heterosexual** **Homosexual**

Occupation: ___________________________________ Religion: ___________________________________