

# Patient Registration Form

Date of Appointment: \_\_\_\_\_

## Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone		Pharmacy Address		

## Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address			City	State	Zip

## Emergency Contact Information

Emergency Contact Name		Emergency Contact Phone	Relation to Patient		
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## Billing and Insurance

### Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

### Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School		Insured's Social Security Number	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	

### Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address		City	State	Zip	

\_\_\_\_\_  
Signature of Patient or Authorized Guardian

\_\_\_\_\_  
Date

Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

**Reason for Visit**

What brings you to the office today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How is your general health?

Excellent  Good  Fair  Poor

Do you have any other concerns you would like to address?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications**

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies**

Are you allergic to any of the following?

- Adhesive Tape
- Barbiturates (Sleeping Pills)
- Codeine
- Antibiotics
- Aspirin
- Sulfas
- Latex
- Iodine
- Local Anesthetics

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

**Past Medical History**

- |   |  |  |   |  |   |
|---|--|--|---|--|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Back Problems     | <input type="checkbox"/> Ear Problems    | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Measles         | <input type="checkbox"/> Skin Disorder    |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Migraines       | <input type="checkbox"/> Stomach Ulcer    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Substance Abuse  |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Joint Disorder         | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Gout            | <input type="checkbox"/> Kidney Disorder        | <input type="checkbox"/> Polio           | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Liver Disorder         | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS / HIV       | <input type="checkbox"/> Depression        | <input type="checkbox"/> Heart Problems  | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stroke          |   |

**Hospitalizations & Surgeries**

Reason	Date
_____	_____
_____	_____

**Lifestyle Factors**

Are you sexually active?

Yes  No # of partners in past year \_\_\_\_\_

Do you wish to be checked for STDs?

Yes  No

Has anyone in your home ever physically or verbally hurt you?

Yes  No

Have you ever smoked?

Yes  No # of years \_\_\_\_\_ # packs/day \_\_\_\_\_

Do you smoke now?

Yes  No # packs/day \_\_\_\_\_

Do you use recreational drugs?

Yes  No types? \_\_\_\_\_ # times/week \_\_\_\_\_

How much alcohol do you drink per week?

# drinks/week \_\_\_\_\_

How much caffeine do you drink per day?

# drinks/day \_\_\_\_\_

How often do you exercise?

# times/week \_\_\_\_\_

**Family History**

Has anyone in your family ever had any of the following conditions?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Joint Disorder        |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Depression          | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Alzheimer's       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Liver Disorder        |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Lung Disease          |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Genetic Disorder    | <input type="checkbox"/> Migraines             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Substance Abuse       |
| <input type="checkbox"/> Blood Disorder    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder      |

Details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Gender \_\_\_\_\_

Age \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

### OBGYN History

Have you ever had or do you currently have any of the following?

- Abnormal Vaginal Bleeding
- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Breast Cancer
- Breast Surgery
- Cervical Cancer
- Chlamydia
- Colposcopy
- Cryosurgery
- DES Exposure
- Extreme Menstrual Pain
- Fibroids
- Genital Warts
- Gonorrhea
- Herpes
- Hot Flashes
- HPV
- Infertility
- Irregular Periods/Bleeding
- Nipple Discharge
- Ovarian Cysts
- Ovarian Cancer
- Painful Intercourse
- Pelvic Inflammatory Disease
- Uterine Cancer
- Urinary Incontinence
- Yeast Infections – Frequent

### Pregnancy History

Please describe any pregnancies you have had.

\_\_\_\_\_

# of Pregnancies    # of Full Term    # of Miscarriages    # of Abortions

#### Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Were there any complications associated with any of your pregnancies?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently pregnant?

Yes  No

Are you trying to become pregnant?

Yes  No

Do you need birth control or contraceptive advice?

Yes  No

What method of birth control do you use?

\_\_\_\_\_

### Menstrual History

When was the first day of your last period?

\_\_\_\_\_

How often does your period occur?

\_\_\_\_\_

How long does your period last?

\_\_\_\_\_

Is your period regular?

Yes  No

What age were you when you had your first period?

\_\_\_\_\_

What age were you at menopause?

\_\_\_\_\_

### Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
<input type="checkbox"/> Blood Sugar-Fasting	_____	_____
<input type="checkbox"/> Breast Self Exam	_____	_____
<input type="checkbox"/> Cholesterol Test	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> CT/CAT Scan	_____	_____
<input type="checkbox"/> Dexascan (Bone Density)	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____
<input type="checkbox"/> Fecal Occult Blood Test	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> Pap Smear	_____	_____
<input type="checkbox"/> Physical Exam	_____	_____
<input type="checkbox"/> Cardiac Stress Test	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____