PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Women's Global Health of Northern Virginia

DATE:

PATIENT INFORMATION

LAST NAME: FIRST NAME: MIDDLE INITIAL: S. S. #:

DATE OF BIRTH: MARITAL STATUS: S M W D SEP EMAIL ADDRESS:

ADDRESS: CITY: STATE: ZIP:

PHONE # HOME: PHONE # WORK: CELL PHONE:

OCCUPATION: EMPLOYER: PHONE #:

SPOUSE/INSURED NAME: DATE OF BIRTH: S. S. #:

OCCUPATION: EMPLOYER: PHONE #:

EMERGENCY CONTACT: (Other than spouse) PHONE #: RELATION:

ADDRESS:

INSURANCE & BILLING INFORMATION

BILLING NAME: (If other than patient) RELATIONSHIP:

BILLING ADDRESS: PHONE:

Payment Required at Time of Service - Unless Prior Arrangements Have Been Made

INSURANCE CO: EFFECTIVE DATE:

ADDRESS:

NAME OF INSURED: RELATION TO PATIENT:

GROUP #: BENEFIT CODE: I.D. #:

MEDICARE #: MEDICARE I.D. #:

OTHER COVERAGE:

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. Bita Motesharrei for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE & MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT (Please print) ______________________ DATE ______________

PATIENT / GUARDIAN (Please print) ______________________ SIGNATURE ______________

PATIENT QUESTIONNAIRE
Women's Global Health of Northern Virginia

NAME: REASON FOR VISIT:

PAST MEDICAL & FAMILY HISTORY

Please check if you (SELF) or any blood relative (FAM) had any of the follwoing conditions

	SELF	FAM			SELF	FAM
1 WT LOSS-GAIN	☐	☐		15 BLOOD TRANSFUSIONS	☐	☐
2 HEADACHES / MIGRAINE	☐	☐		16 ANEMIA / BLOOD DISORDER	☐	☐
3 HEART DESEASE ☐ VALVULAR DIS ☐ RHEUMATIC DIS ☐	☐	☐		17 VARICOSE VEINS / PHLEBITIS	☐	☐
				18 SKIN DISEASE	☐	☐
4 HIGH BLOOD PRESSURE	☐	☐		19 DIABETES	☐	☐
5 HIGH CHOLESTEROL	☐	☐		20 THYROID DISEASE	☐	☐
6 RESPIRATORY DISEASE PULMONARY (LUNG)	☐	☐		21 CANCER	☐	☐
				TYPE	☐	☐
7 BREAST DISEASE	☐	☐		22 EPILEPSY / NEUROLOGICAL DIS.	☐	☐
8 JAUNDICE / HEPATITIS	☐	☐		23 ARTHRITIS - JOINT PAIN	☐	☐
9 HIATAL HERNIA (REFLUX)	☐	☐		24 OSTEOPOROSIS (Fragile Bones)	☐	☐
10 PEPTIC ULCER (STOMACH)	☐	☐				
11 BOWEL DISEASE	☐	☐		25 ANXIETY / DEPRESSON	☐	☐
12 KIDNEY DISEASE	☐	☐		26 SLEEP PROBLEMS	☐	☐
13 URINARY INCONTINENCE	☐	☐				
14 URINARY INFECTIONS	☐	☐				

HOSPITAL ADMISSIONS

List those operations and serious illnesses which required hospitalization (exclude pregnancy)

YEAR	REASON FOR ADMISSION / HOSPITAL	YEAR	REASON FOR ADMISSION / HOSPITAL

MEDICATION

List all medications - you are currently taking (dosage - frequency) - include over the counter drugs

			DRUG ALLERGIES

MENSTRUAL HISTORY

AGE AT FIRST PERIOD: IF MENSTRUATING - DATE OF LAST PERIOD (1st day):

HOW MANY PERIODS IN THE LAST YEAR: BLEEDING (SPOTTING) BETWEEN PERIODS Y N

PERIOD INTERVAL (1st day to 1st day - number of days) DURATION OF BLEEDING CRAMPS Y N ☐ MILD ☐ MOD. ☐ MILD ☐ MOD. MEDICATIONS FOR CRAMPS Y N

VAGINAL INFECTIONS

History of: ☐ YEAST ☐ TRICHOMONAS ☐ CHLAMYDIA ☐ HERPES ☐ GONORRHEA ☐ BACTERIAL VAGINOSIS

PAP TEST

DATE OF LAST TEST: NORMAL ☐ ABNORMAL ☐

MAMOGRAPHY

DATE OF LAST TEST: NORMAL ☐ ABNORMAL ☐

CONTRACEPTIVE HISTORY

CURRENT METHOD: IF PILL- BRAND: PAST METHODS:

OBSTETRICAL HISTORY

NUMBER OF PREGNACIES: PREMATURE BABIES: MISCARRIAGES: ABORTIONS: LIVING CHILDREN:

BORN YEAR/MOS.	WEEKS PREG.	WT	SEX	TYPE OF DEIVERY	REMARKS	BORN YEAR/MOS.	WEEKS PREG.	WT	SEX	TYPE OF DEIVERY	REMARKS
1						4					
2						5					
3						6					

MENOPAUSAL HISTORY

HOT FLASHES Y N TREATMENT:

SEXUAL HISTORY

SATISFACTORY ☐ UNCOMFORTABLE ☐ WISH TO DISCUSS ☐

SOCIAL HISTORY

SMOKING CIG/DAY: # OF YEARS: ALCOHOL OZ/WK: COFFEE CUPS/DAY: STREET DRUGS:

OTHER REMARKS: