Lena Speck Hopkins, MD, PA

PATIENT REGISTRATION FORM

Today's Date:	◯ New Patient ◯ Update ◯ Information Change

PATIENT INFORMATION

Patient's last name:	First:	Middle Name

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	◯ Minor ◯ Married ◯ Widowed ◯ Single ◯ Divorced ◯ Separated	Birth date:	Age:	Sex: ◯ M ◯ F

Address:	City:	Zip Code:

E-mail (required):	Social Security #:	Preferred: [ ] Home#: [ ] Cell# : [ ] Work# :

Race: ◯ American Indian ◯ Asian ◯ Black-African American ◯ White ◯ Other ◯ Decline

Ethic Group: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

RESPONISIBLE PARTY

Responsible party:	Birth date:	Address (if different):	Home phone no.:
Employer:	Occupation:	Employer address:	Employer phone no.:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Name : _____

Patient's relationship to subscriber: : ◯ Self (patient info below) ◯ Spouse (spouse info below) ◯ Child (parent info below) ◯ Other:_____

Subscriber's name:	Subscriber's S.S. no.:	Policy/ ID #	Employer:	Co-payment:
Date of Birth:		Group #:		$

Secondary Insurance Name (if applicable): _____ ◯ Yes (complete info below) ◯ No

Patient's relationship to subscriber: : ◯ Self (patient info below) ◯ Spouse (spouse info below) ◯ Child (parent info below) ◯ Other:_____

Subscriber's name:	Subscriber's S.S. no.:	Policy/ ID #	Employer:	Co-payment:
Date of Birth:		Group #:		$

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize claims to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lena Speck Hopkins, MD, PA or insurance company to release any information required to process my claims.

In case of emergency, if patient is of school age 15+, it is all right to treat in my absence.

_____ _____

Patient/Parent /Guardian signature Date

Lena Speck Hopkins, M.D. PA
Obstetrics & Gynecology
616 Maco Dr. Harlingen, TX 78550
956-264-1600

HIPAA Notification

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact this organization at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but are bound to abide by such restrictions.

Date:_____

Patient name:_____

Relationship to patient:_____

Signature:_____

Lena Speck Hopkins, M.D., P.A.
Obstetrics & Gynecology
616 Maco Drive
Harlingen, TX 78550

Please list the family member(s) or other persons, if any, whom we may inform about your general medical condition or your diagnosis:

_____

_____

In case of emergency, please list the family member(s) or significant other that we may inform about your medical condition:

_____

_____

Please list the telephone number where we may contact you for an appointment reminder if different from your home number: _____

May we leave confidential reminders (I.e. appointment reminder) on your preferred contact number voicemail or answering machine? **YES** **NO**

If you do not have an answering service, may we leave appointment reminders at your place of employment? **YES** **NO**

_____ _____

Print patient name (Guardian, only if under 18 years of age) Relationship to patient

_____ _____

Patient/Guardian signature Date

Lena Speck Hopkins, MD PA

Medical History Form

Name:_____Date:_____

DOB:_____

Marital Status: Single Married Divorced Separated Widowed

Allergies:_____

Latex allergy: YES/NO Iodine allergy: YES/NO

Medications:_____

Last Menstrual Period:_____ Have you had a hysterectomy: YES/ NO

Periods are: Regular Irregular but predictable

Irregular and NOT predictable Infrequent

Do you use or have you ever used contraception: YES/NO

Contraceptive pills Patch Depo Provera injection

Condoms Implanon/Nexplanon Diaphragm IUD /Intrauterine device

Tubal Sterilization/"Tubes tied" Vasectomy Rhythm/Withdrawal

Vaginal Ring

Date of Last Pap:_____

History of Abnormal Paps: YES/NO

Date of Last Abnormal Pap:_____

Last abnormal pap result:

Unsure Atypia/Inflammation Carcinoma in situ Dysplasia HPV

Genital Warts ASCUS LGSIL HGSIL CIN1 CIN2 CIN3

AGUS Adenocarcinoma in situ Adenocarcinoma

Treatment rendered for abnormal pap:

Unsure No treatment Cervical biopsy Cervical Conization/CKC/LEEP

Colposcopy Cryotherapy Efudex Laser ablation Other treatment:_____

Review of Systems:

Constitutional:

Excessive appetite Fever Obesity Unexplained Weight Loss/Weight Gain

Fatigue/Lethargy Decreased Appetite

HEENT:

Blurry Vision Hearing Loss Sinus Pain Sore Throat Vertigo

Nasal Congestion

Cardiovascular:

Slow Heart Rate/Bradycardia Rapid Heart Rate/Tachycardia Shortness of Breath

Positional Shortness of Breath/Orthopnea Irregular Heart Rate Chest Pain

Syncope Varicose Veins

Respiratory:

Chronic Cough Coughing blood/hemoptysis Wheezing

Difficulty Breathing/Dyspnea

Gastrointestinal:

Abdominal Pain Change in Stool Color Blood in Stool/Vomit Nausea

Chronic Constipation/Diarrhea Chronic Vomiting Indigestion Flatulence

Jaundice Hemorrhoids

OB/GYN:

Bloating Bleeding longer than 7 days Crying episodes Depression

Dysmenorrhea/Cramping with menses Heavy Vaginal Bleeding Insomnia

Lack of Energy Loss of Sex Drive Memory Loss Pelvic Pain

Frequent Periods/Metrorrhagia Vaginal Discharge Bloody Discharge

Breast Fullness Cycle Changes Food Craving Hot Flashes Irritability

Heavy Periods/Menorrhagia Night Sweats Postmenopausal Bleeding

Vaginal Dryness

Urinary:

Painful Urination/Dysuria Frequency Hesitancy Leak Urine from Vagina

Leak with Cough/Laugh/Sneeze (Stress Incontinence) Urgency/ Urge Incontinence

Flank Pain Blood in Urine/Hematuria Kidney Infection

Musculoskeletal:

Back Pain Limitation of Motion Muscle Cramps Muscle Weakness

Joint Pain Muscle Pain

Integument/Skin:

Acne Change in Mole Color or Size Hair Loss/Change in Hair Texture

Itching/Pruritus Warts Dry Skin Hirsutism/Coarse Hair Face/Chest/Body

Rash Ulcer

Breast:

Do you do self breast exams? YES/NO

Date of Last Mammogram:_____ Result:_____

Treatment after abnormal Mammogram:_____

Do you have: Breast lump/mass Breast Tenderness

Milky or Other Nipple Discharge

Neurological:

Change in Gait Loss of Balance Tremor Loss of Sensation

Change in Sensation/Paresthesia Change in Speech Loss of Memory

Paralysis Seizures

Psychological:

Anxiety Change in Relationships at Home/Work Depression Irritability

Frequent Awakenings Panic Attacks Change in Mood Crying Episodes

Difficulty Falling Asleep Insomnia Lack of Energy

Autoimmune/Hematologic:

Bleeding Tendencies Easy Bruising Lymph Node Enlargement/Tenderness

Prior Blood Transfusions Excessive Thirst Heat/Cold Intolerance

Past Medical History:

Constitutional:

Anorexia Bulimia Obesity Personal history of Cancer Mental/Physical Disability

HEENT:

Allergic Rhinitis Frequent Strep Throat Headaches Loss of Sense of Smell

Throat Cancer Vertigo Cataracts Glaucoma Hearing Loss Tinnitus Meniere's

Cardiovascular:

Angina Bradycardia Tachycardia Arteriosclerosis Heart Attack Hyperlipidemia

Mitral Valve Prolapse Blood Clot in Legs/Deep Vein Thrombosis Cardiomyopathy

Blood Clot in Lung/Pulmonary embolism Atrial Fibrillation Congestive Heart Failure

Heart Murmur (Antibiotics required for procedures?) Hypertension Pulmonary Hypertension

Phlebitis

Respiratory:

Asthma Emphysema Pneumonia Tuberculosis Chronic Bronchitis

Lung Cancer Rheumatic Fever Live with Someone with TB Positive PPD

Gastrointestinal:

Diverticulitis/Diverticulosis Colon Polyps Gastric Reflux Liver Disease Stomach Ulcers

Cholecystitis Crohn's Disease Irritable Bowel Syndrome Ulcerative Colitis Pancreatitis

Gynecological:

Cervical Cancer Uterine Cancer Chlamydia Genital Herpes PID Clear Discharge

Endometriosis Pelvic Prolapse Salpingitis Vaginitis Ovarian Cancer Vulvar Cancer

Dysplasia CIN2/3 Gonorrhea HPV/Condyloma Syphilis DES Exposure Fibroids

Early Menopause Bacterial Vaginosis Polycystic Ovaries Trichomonas Yeast Infections

Urinary:

Bladder Fistula Kidney Failure Kidney Stones Polycystic Kidney Disease

Chronic Kidney Infection Kidney/Renal Cancer Leaking Urine Recurrent Bladder Infection

Pregnancy History Including Abortions, Miscarriages, Ectopic/Tubal Pregnancies:

Year: Weeks Pregnant: Hrs Labor: Type Delivery: M/F BirthWt: Complications:

Musculoskeletal:

Chronic Back Pain Hip Fracture Osteoporosis Slipped Disk/Spine Fracture

Fibromyalgia Osteoarthritis Pelvic fracture

Skin:

Acne Hirsutism Skin Cancer Melanoma Eczema Psoriasis Vitiligo

Breast:

History of Breastfeeding: How long?

Abnormal Mammogram or Breast Exam: Y/N

Neurological:

Alzheimers Brain Injury Migraines Parkinson's Epilepsy Brain Tumor

Attention Deficit Disorder Multiple Sclerosis Seizures Stroke

Psychological:

Anxiety Depression Obsessive-Compulsive Disorder Suicide Attempt

Bipolar Disorder Panic Attacks

Endocrine:

Adrenal Gland Disease Diabetes Type I / Type 2 Gestational Diabetes

Hypothyroidism Pituitary Tumor Thyroid Goiter Hashimoto's Thyroiditis

Grave's Disease Hyperthyroidism Hyperparathyroidism Thyroid Cancer

Autoimmune/ Lymphatic/ Hematologic:

Anemia D (RH) Sensitized Leukemia Lymphoma Rheumatoid Arthritis
Scleroderma Thrombophilias Von Willebrand or Other Bleeding Disorder
Clotting Factor Deficiency ITP/Low Platelets Lupus Sarcoidosis
Prior Blood Transfusion Sickle Cell Disease/ Trait Thrombophlebitis

Genetic History/Family and Pregnancy History:

Anencephaly Canavan Disease Cystic Fibrosis Familial Dysautonomia
Huntington's Chorea Mental Retardation PKU Sickle Cell Disease/Trait
Tay Sachs Thalassemia Autism Congenital Heart Defect Down Syndrome
Hemophilia Meningomyelocele Muscular Dystrophy Recurrent Pregnancy Loss
Stillbirth Spina Bifida Tested for Fragile X
Other Birth Defects/Inherited/Chromosomal Disorder:

Past Obstetrical/Gynecological Surgeries:

D&C Hysteroscopy Infertility Surgery Tuboplasty Tubal Ligation/Tubes Tied
Laparoscopy Vaginal Hysterectomy Abdominal hysterectomy Myomectomy
Ovarian Surgery Left Ovary Cyst Removal Right Ovary Cyst Removal
Left Ovary Removed Right Ovary Removed Cesarean Section
Bladder Surgery for Prolapse or Incontinence (Abdominal/Vaginal)

Past Surgical History (Not OB/GYN):

Family History:

Diabetes Heart Disease Blood Clotting Disorder DVT/Pulmonary Embolism
Breast Cancer Ovarian Cancer Endometrial/Uterine Cancer
Colon Cancer

Social:

Do you drink alcohol? How much per day? Wine/Beer/Liquor

Do you smoke? How much per day?

Former smoker? When did you quit?

Do you use other drugs (marijuana, cocaine, heroine, etc)? List:

Occupation:

Education:

Religion:

Hospital preference: