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

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 ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

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

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ 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 pregancies 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 where you at menopause?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
☐ Blood Sugar-Fasting		
☐ Breast Self Exam		
☐ Cholesterol Test		
☐ Colonoscopy		
☐ CT/CAT Scan		
☐ Dexascan (Bone Density)		
☐ EKG		
☐ Echocardiogram		
☐ Fecal Occult Blood Test		
☐ Mammogram		
☐ MRI		
☐ Pap Smear		
☐ Physical Exam		
☐ Cardiac Stress Test		
☐ Ultrasound		

Name _____ Gender _____ Age _____ Date of Appointment: _____

Review of Systems

General
- [ ] Chills
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Hair Loss
- [ ] Hair Growth – Excessive
- [ ] Night Sweats
- [ ] Sleeping Problems
- [ ] Thirst - Excessive
- [ ] Weight Gain
- [ ] Weight Loss

Mental Health
- [ ] Anxiety
- [ ] Depression
- [ ] Loss of Interest
- [ ] Feeling Hopeless
- [ ] Hearing Voices
- [ ] Marital Problems
- [ ] Panic Attacks
- [ ] Trouble Concentrating
- [ ] Suicide – Thoughts / Attempts

Musculoskeletal
- [ ] Back Pain
- [ ] Carpal Tunnel Syndrome
- [ ] Joint Pain
- [ ] Joint Swelling
- [ ] Neck Pain
- [ ] Shoulder Pain

Gastrointestinal
- [ ] Appetite Gain
- [ ] Appetite Loss
- [ ] Bloating
- [ ] Bowel Changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Intestinal Disorder
- [ ] Lactose Intolerance
- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Stomach Pain
- [ ] Vomiting
- [ ] Vomiting Blood

Genitourinary
- [ ] Blood in Urine
- [ ] Lack of Bladder Control
- [ ] Frequent Urination
- [ ] Painful Urination

Respiratory
- [ ] Coughing
- [ ] Coughing Up Blood
- [ ] Shortness of Breath
- [ ] Wheezing

ENT
- [ ] Bleeding Gums
- [ ] Blurred Vision
- [ ] Crossed Eyes
- [ ] Difficulty Swallowing
- [ ] Double Vision
- [ ] Earaches
- [ ] Ear Discharge
- [ ] Hay Fever
- [ ] Hoarseness
- [ ] Hearing Loss
- [ ] Nose-Bleeds
- [ ] Persistent Cough
- [ ] Persistent Runny Nose
- [ ] Recurring Sore Throat
- [ ] Ringing in Ears
- [ ] Sinus Problems
- [ ] Vision Halos

Cardiovascular
- [ ] Chest Pains
- [ ] Irregular Heart Beat
- [ ] Circulation Problems
- [ ] Heart Palpitations
- [ ] Rapid Heartbeat
- [ ] Swelling of Ankles
- [ ] Varicose Veins

Skin
- [ ] Acne
- [ ] Bruise Easily
- [ ] Changes in Moles
- [ ] Chills
- [ ] Dry / Sensitive Skin
- [ ] Eczema
- [ ] Hives
- [ ] Itching
- [ ] Rash
- [ ] Scars
- [ ] Sores That Won't Heal

Neurological
- [ ] Coordination Problems
- [ ] Convulsions
- [ ] Difficulty Walking
- [ ] Learning Disabilities
- [ ] Light-headedness
- [ ] Memory Loss
- [ ] Numbness / Tingling
- [ ] Paralysis
- [ ] Seizures
- [ ] Speech Problems
- [ ] Tremors

Other Symptoms

_____

_____

_____

_____

_____

Immunizations

Please check and date all immunizations you have had.

	Month & Year		Month & Year
☐ Hepatitis A	_____	☐ MMR (Measles, Mumps, Rubella)	_____
☐ Hepatitis B (Series of 3)	_____	☐ Pneumonia	_____
☐ HPV Vaccine	_____	☐ Polio	_____
☐ Influenza (Flu Shot)	_____	☐ Tetanus	_____
☐ Meningitis	_____		