**Patient Registration Form**

Legal Name (Last, First, MI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Cell Work

Alternate Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Cell Work

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact: Phone Email

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: Asian Black or African American Native American White/Caucasian Other: \_\_\_\_\_\_\_\_

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex at Birth: Male Female

Gender Identity: Male Female FTM MTF Decline to answer

Relationship Status: Married In Relationship Single Divorced Widowed.

(If Applicable) Name of Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: Full Time Part Time Unemployed Retired Student Other \_\_\_\_\_\_\_\_\_\_\_

Current or Previous Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient is Subscriber/Policy Holder: Yes No Patient is Subscriber/Policy Holder: Yes No

**INSURED INFORMATION** (IF OTHER THAN PATIENT) – Please provide your ID and insurance card Subscriber/ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about this practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

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**Health History**

**Height and Weight Information:**

Current height: \_\_\_\_\_\_\_\_\_ Tallest height: \_\_\_\_\_\_\_ How old were you then? \_\_\_\_\_\_\_\_

Current weight: \_\_\_\_\_\_\_\_\_ Lowest weight as an adult: \_\_\_\_\_\_ How old were you then? \_\_\_\_\_\_\_\_

**Specialist Information:** Please list name, specialty, and location of other physician(s).

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Medications & Supplements**:

Please list any MEDICATIONS you are currently taking, prescribed or over the counter (Please attach extra sheet if needed.)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Route | Frequency |
|  |  |  |  |
|  |  |  |  |
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Preferred Pharmacy (name and address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative Pharmacy (name and address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Known Allergies**: Yes No

If yes, please specify:

|  |  |
| --- | --- |
| Allergy | Reaction |
|  |  |
|  |  |
|  |  |
|  |  |

**Medical History**: (please circle if you have had problems with any of the following)

Anemia Gallbladder disease

Alcoholism Hepatitis

Allergies/Hay Fever Incontinence (urine or feces)

Arthritis Indigestion/GERD/heartburn

Asthma Infertility

Back Pain Kidney disease

Blood Clots Mental health:anxiety, depression, PTSD, ADHD, bipolar

Blood pressure (high/low) Migraine

Breast issues Osteoporosis

Bleeding disorder Pneumonia

Bowel issues: specify - \_\_\_\_\_\_\_\_\_\_\_\_ Prostate issues: specify - \_\_\_\_\_\_\_\_\_\_\_\_

Cancer: specify - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke

Eye issues: specify -\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid disorder: specify - \_\_\_\_\_\_\_\_\_\_\_

Hearing loss Varicose veins

Heart disease: specify - \_\_\_\_\_\_\_\_\_\_\_\_ Seizure disorder

High cholesterol Pre-diabetes / Diabetes

Endometriosis / Fibroids Fractures

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**:

|  |  |  |
| --- | --- | --- |
| Type of Surgery/Procedure | Date (month/year) | Surgeon |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
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|  |  |  |
|  |  |  |

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**Female Reproductive Health History**

**Gynecologic History**

How would you describe your current menstrual status? (circle one)

* Premenopausal (before menopause, having regular periods)
* Perimenopausal (changes in periods, but have not gone 12 months in a row without a period)
* Postmenopausal (after menopause)

Was your menopause:

☐ Spontaneous (“natural”)

☐ Surgical (removal of both ovaries)

☐ Due to chemotherapy or radiation therapy; reason for therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first menstrual period: \_\_\_\_\_\_\_\_\_\_

Are your periods regular? ☐Yes ☐No

Do you have a uterus? ☐Yes ☐No

Do you have both ovaries? ☐Yes ☐No

Do you have a cervix? ☐Yes ☐No

Date of most recent menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If still having periods, how often do they occur? \_\_\_\_\_\_\_\_\_\_\_\_\_

How many days does your period last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your periods painful? ☐Yes ☐No

Do you have heavy periods? ☐Yes ☐No

Do you have spotting or bleeding between periods? ☐Yes ☐No

Do you have other problems with your period? ☐Yes ☐No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have PMS? ☐Yes ☐No

Do you examine your breasts? ☐Yes ☐No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_

Did your mother take DES when she was pregnant with you? ☐Yes ☐No

Do you douche? ☐Yes ☐No

Have you ever used hormone therapy for menopause? ☐Yes ☐No

If yes, which medications and for what reasons? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Obstetrical History**

Are you currently using any form of birth control? ☐Yes ☐No

If so, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other forms of birth control have you used in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_\_\_\_

How many children do you have? \_\_\_\_\_\_\_\_\_\_\_

How old were you when your first child was born? \_\_\_\_\_\_\_\_\_\_\_\_

How old were you when your last child was born? \_\_\_\_\_\_\_\_\_\_\_\_

Please provide the number of your:

Full term births: \_\_\_\_ Premature births: \_\_\_\_ Miscarriages: \_\_\_\_ Abortions: \_\_\_\_ Living children: \_\_\_\_ Any maternal complications during pregnancy, delivery or postpartum (i.e. hypertension, preeclampsia/eclampsia, gestational diabetes, blood clots)? ☐Yes ☐No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual History**

Are you currently sexually active? ☐Yes ☐No

If yes, are currently having sex with: ☐A man (or men) ☐A woman (or women) ☐Both men and women

How long have you been with your current sex partner? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in a committed, mutually monogamous relationship? ☐Yes ☐No

If no, do you use condoms (practice safe sex)? ☐Yes ☐No

In the past, have you had sex with: ☐Men ☐Women

Have you had any sexually transmitted infections? ☐Yes ☐No

Do you have concerns about your sex life? ☐Yes ☐No

Do you have a loss of interest in sexual activities (libido, desire)? ☐Yes ☐No

Do you have a loss of arousal? ☐Yes ☐No

Do you have a loss of response (weaker or absent orgasm)? ☐Yes ☐No

Do you have any pain with intercourse (vaginal penetration)? ☐Yes ☐No

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**Family History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relative** | **Health issues** | **Age at Diagnosis** | **Age of Death** |
| Mother |  |  |  |
| Father |  |  |  |
| Sibling #1 (M/F) |  |  |  |
| Sibling #2 (M/F) |  |  |  |
| Sibling #3 (M/F)  Child #1 (M/F) |  |  |  |
| Child #2 (M/F) |  |  |  |
| Child #3 (M/F) |  |  |  |
| Maternal Grandmother |  |  |  |
| Maternal Grandfather |  |  |  |
| Paternal Grandmother |  |  |  |
| Paternal Grandfather |  |  |  |
| Other |  |  |  |

**Social History/Personal Habits**

**Exercise**

What kind of exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often and how long do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Diet**

Are you on any special diet? ☐Low-fat ☐Low carbohydrate ☐High protein ☐Vegetarian/Vegan

What dairy products do you consume each day? How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have lactose intolerance? ☐Yes ☐No

Do you have issues with gluten? ☐Yes ☐No

How many servings of fruit do you consume each day? \_\_\_\_\_\_\_\_\_

How many servings of vegetables do you consume each day? \_\_\_\_\_\_\_\_

How many servings of fish do you consume each week? \_\_\_\_\_\_\_\_

**Tobacco Use**

Do you currently smoke cigarettes? ☐Yes ☐No

If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did you start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not currently smoking, have you ever smoked? ☐Yes ☐No

If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did you start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you stop? \_\_\_\_\_\_\_\_\_\_

Do you use any other type of tobacco? ☐Yes ☐No

If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caffeine Use**

Do you consume drinks with caffeine (coffee, tea, soda drinks)? ☐Yes ☐No

If yes, how many drinks each day? \_\_\_\_\_\_\_\_\_\_

**Alcohol and Drug Use**

Do you drink alcohol? ☐Yes ☐No

If yes, how many drinks do you have each week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever have a drink in the morning to get you going? ☐Yes ☐No

Have you ever tried to cut down on your drinking? ☐Yes ☐No

Have you ever felt guilty about the amount you drink? ☐Yes ☐No

Have you ever been an alcoholic? ☐Yes ☐No

Do you use illegal drugs? ☐Yes ☐No

**Abuse**

Within the last year, have you been hit, slapped, kicked, or physically hurt by someone? ☐Yes ☐No

Within the last year, has anyone ever forced you to have sexual activities? ☐Yes ☐No

Within the last year, has anyone verbally or emotionally abused you? ☐Yes ☐No Have you had counseling for these issues? ☐Yes ☐No

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**Preventative Healthcare**

**Date of Last:**

Complete Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap Smear (Female): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/STD testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis C testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate Exam/PSA (Male): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Vaccines:**

Tetanus/TDAP/Td: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flu Shot \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles \_\_\_\_\_\_\_\_\_\_\_\_\_\_ COVID-19 \_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumovax \_\_\_\_\_\_\_\_\_\_\_\_\_ Prevnar \_\_\_\_\_\_\_\_\_\_\_\_\_\_

HPV \_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any genetic screening tests for cancer or other inherited diseases? ☐Yes ☐No

Result of genetic test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a living will or Advanced Directive? ☐Yes ☐No

Do you have a healthcare proxy? ☐Yes ☐No

If yes, please bring a copy with you to your appointment.

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