

CLIENT REGISTRATION FORM

CLIENT INFORMATION

(Please print)

Client's Legal Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Preferred Full Name (if different from above): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone Number (landline): \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender Identity:  Female  Male  Transgender Female to Male  Transgender Male to Female  Genderqueer  Choose not to disclose  
 Additional Gender category not listed \_\_\_\_\_

Race:  American Indian/Alaska Native  Asian  Native Hawaiian/Pacific Islander  Black/African American  White  
 Hispanic  Chose not to disclose  Other not listed \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Choose not to disclose

RESPONSIBLE PARTY INFORMATION (If not self)

Responsible party:  Another patient  Guarantor  Self Check here if address and telephone information is same as patient

Responsible party name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of birth: MM\_\_\_\_/DD\_\_\_\_/YYYY\_\_\_\_ Sex:  Female  Male

Responsible Party Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE: I do not participate with any insurance plans. If you would like a receipt to submit to your insurance company one can be provided upon request.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Phone number: \_\_\_\_\_ Do you have a living will?  Yes  No

Emergency contact relationship to patient: \_\_\_\_\_  Guardian

Address \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work hone: \_\_\_\_\_ Ext. \_\_\_\_\_

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE CLIENT: You have the right, as a client, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request my provider to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).  
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of client or personal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of client or personal representative: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

## **GYNECOLOGIC HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Chief reason for today's visit: \_\_\_\_\_

First day of last menstrual period: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Results: \_\_\_\_\_

Type of birth control currently using: \_\_\_\_\_  
(including vasectomy, tubal ligation, condoms, abstinence, or natural family planning methods)

Are you happy with this method of birth control? \_\_\_\_\_

Were you referred to our office? If so please tell us by who. \_\_\_\_\_

### **OBSTETRICAL HISTORY**

Are you currently pregnant? **Y N** If so, on what date was first positive pregnancy test? \_\_\_\_\_

Total number of times pregnant (include miscarriages and abortions): \_\_\_\_\_

Total number of live births (include dates and type of delivery): \_\_\_\_\_

Total number miscarriages: \_\_\_\_\_ Total number abortions: \_\_\_\_\_

Any complications during your pregnancies? If so, please explain: \_\_\_\_\_

Did you have a Caesarean Section? If so, when: \_\_\_\_\_

Any family history of inherited disorders (i.e. Tay Sachs, Spina Bifida, Down Syndrome, other genetic disorder)?

### **GYNECOLOGICAL HISTORY**

Age at first period: \_\_\_\_\_ How many days do your periods last? \_\_\_\_\_

How often do your periods come?  Every 28-30 days  More frequently  Less frequently

How heavy is your menstrual flow?  Light  Moderate  Heavy  Extremely Heavy

Do you have bad cramps? **Y N** Do you have any PMS symptoms? **Y N**

Any bleeding between periods? **Y N** Any bleeding after intercourse? **Y N**

Any problems with urination (loss of urine while coughing, sneezing, etc.)? **Y N**

Check any of the following problems that you have had either in the past or currently:

Gonorrhea  Pelvic Inflammatory Disease (PID)  Herpes  Vaginal Infections

History of physical or sexual abuse  IUD Related problems

Abnormal pap smears (what abnormality and when)? \_\_\_\_\_

**MEDICAL HISTORY**

How is your health in general?     Excellent     Good     Fair     Poor

Do you smoke?    **Y**    **N**    How much? \_\_\_\_\_ packs per day    How many years have you smoked? \_\_\_\_\_

Are you a past smoker?    **Y**    **N**    When did you quit? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

Do you drink alcohol?    **Y**    **N**    How many alcoholic beverages do you have in a week? \_\_\_\_\_

Social drug use?    **Y**    **N**    If so, what type of drugs do you use? \_\_\_\_\_

Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when? \_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized for a medical illness? If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

What surgeries have you had? (please give year of surgery, including cosmetic): \_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to medications?    **Y**    **N**

Do you have any other allergies?    **Y**    **N**

Please List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any history of a bleeding disorder?    **Y**    **N**    Had a blood transfusion?    **Y**    **N**

Do you use medication on a regular basis? Please list name and dose of medication: \_\_\_\_\_  
\_\_\_\_\_

Have you had a mammogram?    **Y**    **N**    Date & result of last mammogram: \_\_\_\_\_

Do you have any problems with your breasts? (lumps, discharge, or pain)? \_\_\_\_\_

**FAMILY HISTORY** (Please check if anyone in your family has any of these conditions and tell us who has it)

- Breast Cancer     Uterine Cancer     Ovarian Cancer     Colon Cancer
- Diabetes     Heart disease     High Blood Pressure     Stroke
- Osteoporosis     Thyroid disease     Autoimmune     Other

**SOCIAL HISTORY**

Marital status:    **M**    **S**    **D**    **W**    **P**

Occupation: \_\_\_\_\_ Religion: \_\_\_\_\_