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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: _____