

Chart #:
D.O.B:
Name:

Women's Med

Registration

(Please Complete Entire Form)

Date: ____ / ____ / ____

Thank you for choosing Women's Med.
Each staff member has a personal commitment to meet your medical and emotional needs.
Please let us know if you have any questions or concerns during your visit.

Name: _____
(First, Middle Initial, Last) (Maiden, Former Married Names)

Home Address: _____
(Street Address, Not P.O. Box)

City: _____ State: _____ Zip: _____

Social Security#: _____ Birthdate: _____

Home Phone#: () _____ Work Phone#: () _____

Person Responsible For This Bill? _____

Home Phone#: () _____ Work Phone#: () _____

I understand you may have to contact me for medical or laboratory follow-up.

_____ I do **not** wish to be contacted at home.

_____ You may reach me by calling: () _____ OR () _____

OR by writing me care of:

(Name) _____ (Address) _____

(City) _____ (State) _____ (Zip) _____

OR by contacting my physician:

(Name) _____ (Address) _____

(City) _____ (State) _____ (Zip) _____

Whom May We Call in Case of Emergency Who Does Not Reside With You?

TM

Name: _____ Phone#: () _____ Relationship: _____
Responsible Party

Patient Signature _____ Signature _____

Women's Med

Medical History

Chart #:

Date: ____ / ____ / ____

**** Please complete both sides of this form ****

Patient Name: _____

Date of Birth: ____/____/____ Age: _____

List your allergies: _____

List all medications you are currently taking: _____

What is your blood type? ____ Rh? ____

Have you had any of the following conditions?

	Yes	No		Yes	No
Reaction to Sedation	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to General Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Free Bleeding or Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
TB or Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur/Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/ Seizures/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots in Legs/Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/ Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Sugar	<input type="checkbox"/>	<input type="checkbox"/>	Bi-polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Adrenal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pituitary Gland Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery	<input type="checkbox"/>	<input type="checkbox"/>

Has any member of your family had any of the following?

	Yes	No		Yes	No
Blood Clots in Legs/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Do you smoke? _____ Do you drink alcohol? _____ How many drinks per week? _____

Do you use or have you ever used recreational drugs? YES or NO

If yes, when was the last time you used recreational drugs? _____

What kind? _____

Do you now or have you ever experienced physical, sexual or emotional abuse? YES or NO

Is there anything else we should know about your health? YES or NO

Explain all yes answers here:

Women's Med Medical History

Chart #:

Date: ____ / ____ / ____

**** Please complete both sides of this form ****

Date Last Normal Period Started (if known) _____

	Yes	No		Yes	No
Have you had a positive pregnancy test?	<input type="checkbox"/>	<input type="checkbox"/>	Were you using birth control when you became pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having any problems with this pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	Are you Nursing?	<input type="checkbox"/>	<input type="checkbox"/>

Explain any yes answers here:

What type of birth control would you like to use now? _____

What other type of birth control have you used previously? _____

Previous Pregnancies					
#Children Born Alive		#Premature		#Stillborn or Miscarriages	
#C-section		#Tubal/Ectopic		#Previous Abortions	

Mark and describe any problems you have had with a previous pregnancy:

- High Blood Pressure
 Eclampsia
 HELLP Syndrome
 Heart Problems
 Excessive Vomiting
 Darkening of Skin
 Molar Pregnancy
 Fetal Abnormality
 Placenta Accreta
 Placenta Previa
 Other Problems with Placenta
 Other _____

Have you ever had or have any of the following:

	Yes	No		Yes	No
A Pelvic Exam	<input type="checkbox"/>	<input type="checkbox"/>	Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>
Problems W/Birth Control	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>
PID /Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	Fibroids/Cysts	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Disease	<input type="checkbox"/>	<input type="checkbox"/>
Has your partner ever had an STD?	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Ectopic or Tubal Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Infection of Ovary or Tube	<input type="checkbox"/>	<input type="checkbox"/>	GYN Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Other Ovary/Tube Problems	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Surgery to the Cervix: Conization, LEEP, Cryosurgery, Colposcopy?	<input type="checkbox"/>	<input type="checkbox"/>	Other Female or Vaginal Infections	<input type="checkbox"/>	<input type="checkbox"/>
Tubal Ligation or Occlusion	<input type="checkbox"/>	<input type="checkbox"/>	Other Female Problems	<input type="checkbox"/>	<input type="checkbox"/>

Explain any "yes" answers here: