Women's Med

Registration &
Medical History

Please print and fill out the following pages prior to your appointment.

Completing these pages before your appointment will reduce the time you will need to spend in our office.

Thank You

Chart #:
D.O.B:
Name:

For Office Use

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:_____

Cell Phone#: ( )_____ Home Phone#: ( )_____

☐ I wish to receive SMS text reminders for appointments on my cell ☐ I do not wish to receive test reminders

Person Responsible For This Bill?_____

Cell Phone#: ( )_____ Home Phone#: ( )_____

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

☐ I do **not** wish to be contacted on my cell or at home You may reach me by calling: ( )_____

OR by writing me ☐ at my home address above **OR** ☐ at the address below:

(Name)_____(Address)_____

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

OR by contacting my physician:

(Name)_____(Address)_____

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

Whom May We Call in Case of Emergency?

Name:_____ Phone#: ( )_____Relationship:_____

Patient Signature_____

Responsible Party Signature_____

Chart #:
D.O.B:
Name:

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Medical History

(Please Complete Entire Form)

Date: ____ /____ /____

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	☐	☐	Crohn's Disease	☐	☐
Reaction to General Anesthesia	☐	☐	Free Bleeding or Hemorrhage	☐	☐
Sleep Apnea	☐	☐	Blood Transfusion	☐	☐
Respiratory Problems	☐	☐	Anemia	☐	☐
TB or Lung Problems	☐	☐	Sickle Cell	☐	☐
Asthma	☐	☐	Heart Disease/Attack	☐	☐
Heart Murmur/Mitral Valve Prolapse	☐	☐	High Blood Pressure	☐	☐
Rheumatic Fever	☐	☐	Fainting Spells	☐	☐
Migraine Headaches	☐	☐	Varicose Veins	☐	☐
Epilepsy/ Seizures/ Convulsions	☐	☐	Blood Clots in Legs/Lungs	☐	☐
Stroke/Numbness	☐	☐	Depression	☐	☐
Thyroid Disease	☐	☐	Anxiety Disorder	☐	☐
Diabetes/Sugar	☐	☐	Bi-polar Disorder	☐	☐
Hepatitis/Liver Disease	☐	☐	Kidney Problems	☐	☐
Infectious Mononucleosis	☐	☐	Adrenal Problems	☐	☐
Psychiatric Treatment	☐	☐	Birth Defects	☐	☐
Cancer	☐	☐	Pituitary Gland Problems	☐	☐
Other Serious Illness	☐	☐	Major Surgery	☐	☐

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

	Yes	No		Yes	No
Blood Clots in Legs/Lungs	☐	☐	Cancer	☐	☐

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:

Chart #:
D.O.B:
Name:

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(Please Complete Entire Form)

Date: ____ /____ /____

Date Last Normal Period Started (if known) _____

	Yes	No		Yes	No
Have you had a positive pregnancy test?	☐	☐	Were you using birth control when you became pregnant?	☐	☐
Are you having any problems with this pregnancy?	☐	☐	Are you Nursing?	☐	☐

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

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

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

Have you ever had or have any of the following:

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

Explain any "yes" answers here: