Account #_____

OB•GYN ASSOCIATES OF WNY
Proudly Partnering with General Physician PC

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## PATIENT REGISTRATION

### PATIENT INFORMATION:

Name:_____ Date of Birth: ____/____/____
Preferred Name: _____

Social Security #_____ Email Address:_____

Mailing Address:_____ City/Zip Code:_____

Home Phone:(____)_____ Cell Phone:(____)_____

Preferred Phone: Home ☐ Cell ☐

Primary Care Physician:_____ Referring Physician:_____

Emergency Contact:_____ Daytime Phone (___)_____

How Did You Hear About Us? Phone Book ☐ Web ☐ Newspaper ☐ Family/Friends ☐ Other ☐ _____

### INSURANCE INFORMATION:

Co-Pay:_____(Required at Check-In) Primary Insurance:_____

ID#_____ Group #_____ Employer: _____

Policy Holder: _____ Relationship: _____ DOB:____/____/____

**Secondary Insurance**: _____

ID#_____ Group #_____ Employer: _____

Policy Holder: _____ Relationship: _____ DOB:____/____/____

### RESPONSIBLE PARTY INFORMATION: **(For Patients Under 18 Only)**

Name: _____ Relationship: _____ DOB:____/____/____

Mailing Address: _____ City/Zip Code: _____

### INFERTILITY PATIENT INFORMATION:

Male Donor Name:_____ Relationship: _____ DOB:____/____/____

Insurance Carrier: _____ ID# _____

Account #_____

**Date:** _____

Name: _____ Primary Pharmacy: _____

Primary Care Physician: _____ Secondary Pharmacy: _____

Referred By: _____ Mail Order Pharmacy: _____

Date of Birth: _____ Race: _____ Ethnicity: _____

Primary Language: _____

Gender Identity: ☐Female ☐Male ☐Nonbinary ☐Choose not to disclose
Preferred Pronoun_____ Other_____

Briefly state the reason for your visit today:

_____

_____

Other Physicians you currently see

| Physician | Specialty | Date last seen |
|---|---|---|
| | | |
| | | |
| | | |

Current Medications (please include Vitamins/Herbal supplements) Additional medication write on back

| Name | Dosage | Prescriber |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Drug Allergies: ☐No known drug allergies

| Drug Name | Reaction |
|---|---|
| | |
| | |
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Account #_____

**Well Woman Update**

Age of first menstrual period: _____ If menopausal, age of menopause: _____

First day of your last menstrual period: _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days.

Are your cycles: ☐Regular? ☐ Irregular if so how? _____

Are you sexually active? ☐ Never ☐Not currently ☐ Yes

With: ☐Men ☐Women ☐ Both

Number of lifetime sexual partners: _____

**Well Woman Update (cont.)**

Last Bone Density Date: _____ Result: _____

Last Colonoscopy Date: _____ Result: _____

Last Mammogram Date: _____ Result: _____

Last Pap Smear Date: _____ Result: _____

Any abnormal Pap Smears? ☐Yes ☐ No

If yes, any treatment?

Colposcopy date: _____ LEEP Date: _____ Cryotherapy (freezing) Date: _____

Colposcopy Result: _____ LEEP/cold knife cone Result: _____

HPV/Gardasil Vaccine Series completed? ☐Yes ☐ No

Have you had the Hepatitis B series? ☐Yes ☐No

**Method of contraception:**

☐ Not needed ☐Vasectomy ☐Tubal Ligation ☐Condoms ☐NuvaRing

☐ None ☐Pill ☐Patch ☐Depo Provera

☐IUD (type & date inserted) _____

☐ Nexplanon (date inserted) _____ ☐Right Arm ☐ Left Arm

Account #_____

**Obstetrical History**

Please list all pregnancies, **<u>including</u>** miscarriages, abortions, chemical, and ectopic pregnancies. First line is an example to follow. Write any additional pregnancies on back.

Have you been tested for Cystic Fibrosis? If so where and when: _____

| Delivery Date | Weeks | Length of Labor (hours) | Baby's Weight | Sex | Type of Delivery | Anesthesia | Complications |
|---|---|---|---|---|---|---|---|
| EXAMPLE 1/15/75 | 40 | 12 | 6Lb.2oz | F | Vaginal | Epidural | High Blood pressure |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Medical History**

Have you had chicken pox? ☐Yes ☐ No If no, were you vaccinated? ☐Yes ☐No ☐Unsure

Do you know your blood type? ☐Yes ☐No If yes, what type: _____

Do you now have or have ever been diagnosed with?

| | | |
|---|---|---|
| ☐ Asthma<br>☐ Auto Immune Disorder<br>Type: _____<br>☐Bleeding Disorder<br>Type: _____<br>☐ Bone/Joint Disease<br>☐ Cancer<br>Type: _____<br>☐ Deep Vein Thrombosis<br>☐ Depression<br>☐Diabetes<br>Type: _____ | ☐ High Cholesterol<br>☐ Endometriosis<br>☐ Fibroids<br>Type: _____<br>☐ Heart Disease<br>☐Hepatitis<br>Type: _____<br>☐ Herpes<br>Type: _____<br>☐ HIV<br>☐ HPV | ☐ High blood Pressure<br>☐ Infertility<br>☐ Liver Disease<br>☐ Migraines<br>☐ Migraines with Aura<br>☐Osteopenia<br>☐ Osteoporosis<br>☐ Pulmonary Embolism<br>☐ Seizure Disorder<br>☐ Syphilis<br>☐ Thyroid Disease<br>Not Listed:<br>_____<br>_____<br>_____ |

Account #_____

| | | |
|---|---|---|
| | | |

**Surgical History:** (Please list **ALL** surgical procedures, including year and surgeon)

_____
_____
_____
_____

**Please list any non-surgical hospitalizations:** (dates and reasons)

_____
_____
_____

**Family History**

Has anyone in your immediate family been diagnosed with the following. If so who, age of diagnosis, stage and treatment.

Breast Cancer: _____

Colon Cancer: _____

Ovarian Cancer: _____

Uterine Cancer: _____

| | Age: | Any Major Illness: | If deceased, cause of death: |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Brother | | | |
| Sister | | | |
| Children | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Aunts/Uncles | | | |

Account #_____

| | | | |
|---|---|---|---|
| | | | |

**Social History**

Highest Level of education completed: _____

Are you?

☐ Married ☐Engaged ☐ In a relationship ☐ Single ☐ Legally Separated ☐ Divorced ☐ Widowed

Partner's name and gender: _____

Work Status: ☐ Full Time ☐ Part time ☐Disabled ☐Retired ☐Unemployed ☐Homemaker

Occupation: _____

Tobacco Use: ☐ Never ☐ Current _____# of Cigarettes per day ☐ Former, Quit at age: _____

Do you use another form of nicotine (i.e.: vape) ☐ Yes ☐ No *If yes what? _____

Alcohol use? ☐ Yes ☐ No *If yes, the average number of drinks per week_____

Do you use street drugs? ☐Yes ☐ No *If yes, the type used and last use_____

Have you ever been diagnosed with any of the following?

Herpes (Type 1 or 2/ oral or genital): _____

Gonorrhea☐ Chlamydia☐ Trichomoniasis☐ HPV☐

Religion: _____ Exercise: _____

Hours of sleep: _____ Hobbies: _____

Special Diet: _____ Coffee: Yes ☐No☐ If yes, cups per day _____

Recent travel outside USA: _____