PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ___________ Age: _____

SSN: _______________ Race: __________ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Home Address: ____________________________ City, State & Zip Code: ___________________

Home Phone: _________________ Work Phone: ________________ Cell Phone: _____________

Email Address: _____________________________ Employer: ___________________________

Primary Care Physician: ______________________ Primary Care Address: ___________________

Preferred Pharmacy: ____________________ Pharmacy Address: ______________________________

POLICYHOLDERS INFORMATION (If different from patient)

Name: ______________________________ Date of Birth: ______________________

SSN: ____________________ Relationship to Insured: ☐Spouse ☐Parent/Guardian

PRIVACY INFORMATION (HIPAA)

I authorize Wilson OB-GYN to contact me and/or to leave messages in the following ways:

☐Home Phone ☐Work Phone ☐Cell Phone ☐E-mail

I authorize Wilson OB-GYN to release my medical information to the named person(s) listed below:

☐Spouse/Parents/Children: ____

☐Other (Relationship to the Patient) ____

OFFICE POLICY

- **LATE** – If you arrive more than 15 minutes late for your appointment you may be asked to reschedule.
- **PRESCRIPTION REFILLS** – Call your pharmacy and ask them to **fax a refill request to our office.** DO NOT wait until you are out of your medicine. Refill requests take 24-48 hours.
- **FORMS** – FMLA forms requiring medical review and physician signature will be completed within 7-10 business days with a fee of $20. Please allow plenty of time for completion.
- **PATIENT CONFIDENTIALITY** – In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the Wilson OB-GYN Notice of Privacy Practices is available to all patients in the office or online at www.wilsonobgyn.com.

READ & SIGN BELOW

I certify that the information provided is correct and complete to the best of my knowledge. I have read, understand and agree to the above Office Policy.

________________________________ ______________________

Signature of Patient (or Legal Guardian) Date

Name: ______________________ Date: ______________________

MEDICAL HISTORY FORM

In your own words, please write the nature of the medical reason for which you are being seen.

____

____

____

Medical Problems/Illnesses

*Do you have any of the following?

Condition	Yes	No
Glaucoma	□Yes	□No
Kidney Disease	□Yes	□No
Recurrent Bladder Infections (UTI's)	□Yes	□No
Heart Problems	□Yes	□No
Blood clots/DVT	□Yes	□No
Hypertension	□Yes	□No
Bleeding Disorder	□Yes	□No
High Cholesterol	□Yes	□No
Liver Disease	□Yes	□No
Fibroids	□Yes	□No
Anxiety/Depression	□Yes	□No
Asthma	□Yes	□No
Ovarian Cysts	□Yes	□No
GERD/Ulcers	□Yes	□No
Hepatitis	□Yes	□No
Diabetes	□Yes	□No
Thyroid Disease	□Yes	□No
Osteoporosis/penia	□Yes	□No
Seizures/Epilepsy	□Yes	□No
Stroke	□Yes	□No
Migraine Headaches	□Yes	□No
Anemia	□Yes	□No
Blood Transfusion	□Yes	□No
Cancer ,Type:__________	□Yes	□No
Lupus	□Yes	□No
HIV/AIDS	□Yes	□No
Gonorrhea/Chlamydia	□Yes	□No
Lung Disease	□Yes	□No
Syphilis	□Yes	□No

Other:_________________________

Medications

____
____
____
____
____
____
____
____
____
____
____
____

Allergies

Medications	Reactions
______________	__________
______________	__________
______________	__________

Social History/Habits

*Do you use?

Habit	Yes	No	Details
Alcohol	□Yes	□No	Drinks per week: _____
Tobacco	□Yes	□No	Packs per day: _____
Illicit Drugs	□Yes	□No	Type: ____________

Name: ______________________________ Date: _______________

Family History

Any history of the below conditions in your family? Please list relationship in space below.

Ovarian Cancer	____________	Pancreatic Cancer	__________
Uterine Cancer	____________	Diabetes	__________
Endometrial Cancer	____________	Stroke/Blood Clots	__________
Cervical Cancer	____________	Bleeding Disorders	__________
Vaginal Cancer	____________	Colon Cancer	__________
Breast Cancer	____________		

Surgeries

Surgery	Reason	Year	Hospital

Obstetrics/Gynecologic History

Age of First Period	__________	Number of Pregnancies	________
Age of Last Period	__________(if postmenopausal)	Number of Miscarriages	________
Cycle Length	_____days between each period	Number of Terminations	________
Period Length	_____days of bleeding	Ectopic Pregnancies	________
First day of last period	__________	Number of living children	________
Last Pap Smear	__________	Last Mammogram	________
Last DEXA	__________	Last Colonoscopy	________

Did you receive Gardasil (HPV) Vaccine ☐Yes ☐No ☐Unsure

Current Contraception (birth control) ____

Including permanent sterilization

Delivery History

Date of Birth (M/D/YY)	Full Term(over 37 weeks) Or Preterm	Type of Delivery (Vaginal or C-section)	Complications	Weight	Boy/Girl

*Please indicate for each pregnancy whether spinal, IV Medications, Epidural, or None