Lunt and Kvarfordt, LLC. **DATE: ____________________**

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (FIRST -- MIDDLE INITIAL -- LAST)		
PATIENT SOCIAL SECURITY #	DATE OF BIRTH	SEX ❑ Male ❑ Female
MAILING ADDRESS		
CITY, STATE, ZIP		
HOME PHONE #	WORK PHONE #	CELL PHONE #
PREFERRED PHONE # ❑ Home ❑ Work ❑ Cell	EMAIL ADDRESS	

REQUIRED BY NEW FEDERAL REGULATIONS

RACE	ETHNICITY	PREFFERED LANGUAGE	MARITAL STATUS ❑ Single ❑ Married ❑ Other________________

PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE
PREFERRED PHARMACY	PRIMARY DOCTOR	REFERRING DOCTOR

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
ID NUMBER	GROUP NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
ID NUMBER	GROUP NUMBER	EMPLOYER	EMPLOYER PHONE

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

How did you hear about our office?
❑ Internet ❑ Phone Book ❑ Facebook ❑ Friend/Family: ____________________________ ❑ Other: ____________________________

Authorization to release health information to: (EXAMPLE: SPOUSE/PARTNER, PARENT, CHILD)

Name(s)	
PHONE	
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:

Release the following information:
❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):

Lunt and Kvarfordt, LLC. **DATE:** ____________________

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	Date of Birth
What is the reason for your visit today?	
Allergies: ☐No Known Drug Allergies	

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed	❑ DVT/Pulmonary Embolism	❑ Lung Disease	❑ Stroke
❑ Anemia	❑ Eczema, Rashes, Hives	❑ Measles	❑ Syphilis
❑ Arthritis Type: ____________	❑ Eye Conditions: ___________	❑ Migraines	❑ Hypothyroid
❑ Bacterial Vaginosis	❑ Gonorrhea	❑ Mumps	❑ Hyperthyroid
❑ Cancer Type: _____________	❑ HPV/Genital Warts	❑ Osteoporosis	❑ Endometriosis
❑ Chicken Pox ❑ Vaccinated?	❑ Heart Conditions: __________	❑ PCOS	❑ Trichomoniasis
❑ Chlamydia	❑ Herpes	❑ Polio	❑ Tuberculosis
❑ Depression	❑ High Blood Pressure	❑ Rheumatic Fever	❑ Venereal Disease
❑ Diabetes	❑ HIV/AIDS	❑ Rubella	❑ Weight Loss (recent)
❑ Dizziness	❑ Liver Disease	❑ Scarlet Fever	❑ Weight Gain (recent)

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

	YES	NO	YEAR		YEAR
C-Section				Other:	
Appendectomy ☐**Open** ☐**Laparoscopic**				Other:	
Gall Bladder ☐**Open** ☐**Laparoscopic**				Other:	
Tonsils				Other:	
Wisdom Teeth				Other:	

FAMILY HISTORY – **Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.**

❑ Adopted – History Unknown

	MOTHER		FATHER		SIBLING		GRANDPARENT	
	LIVING	DECEASED	LIVING	DECEASED	LIVING	DECEASED	LIVING	DECEASED
Alcoholism								
Anemia								
Arthritis								
Cancer – **specify type**								
Diabetes								
Drug Abuse								
Blood Clots								
Epilepsy								
Glaucoma								
Heart Disease								
High Blood Pressure								
Hypothyroid								
Kidney Disease								
Migraine								
Osteoporosis								
Stroke								
Suicide Attempt								
Thyroid Disease								
Ulcer								

SOCIAL HISTORY

☐**Yes** ☐**No -** Have you ever used tobacco? ☐ Smoke (___ packs per day) ☐ Chew ☐ Quit Smoking Date:_________

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐Socially ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you use recreational drugs? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Addict

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Lunt and Kvarfordt, LLC. **DATE: ____________________**

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**Date of Birth**

Medications: List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING

OB/Gyn History

Age when you first started your menstrual cycle:	What do you currently do to prevent pregnancy? ☐Oral/Pills ☐Patch ☐Tubal Ligation ☐IUD ☐Vasectomy ☐Depo-Provera ☐Condoms ☐Hysterectomy ☐None ☐Other:
First day of your last menstrual cycle:	
Number of days your menstrual period lasts:	
Number of days in between menstrual cycle:	
Date of your last PAP Smear: ____________________________	RH Negative ☐**Yes** ☐**No**
☐Unknown ☐Never	Have you ever had vaginal intercourse: ☐**Yes** ☐**No**
Have you ever had an abnormal PAP Smear? ☐**Yes** ☐**No**	Do you douche? ☐**Yes** ☐**No**
When was your last mammogram - Date:	If yes how often?
Total # of Pregnancies (including current):	When did you last douche?
Number of children still living:	Are you sexually active now? ☐**Yes** ☐**No**
How many of these pregnancies were:	Have you experienced pain with intercourse? ☐**Yes** ☐**No**
Full term (37-40 weeks): _____	Have you recently had sex with a new partner? ☐**Yes** ☐**No**
Premature: _____	Have you ever had intercourse against your will? ☐**Yes** ☐**No**
Miscarriages: _____	Have you previously or currently been abused by your partner? ☐**Yes** ☐**No**
Abortions: _____	
Ectopic Pregnancies: _____	Do you do monthly breast exams? ☐**Yes** ☐**No**
Multiple Births: _____	Have you experienced emotional change recently? ☐**Yes** ☐**No**
List any pregnancy complications:	

Review of Systems Please mark any of the following signs or symptoms that you are currently experiencing:

- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Back Pain
- ☐ Blood in Urine
- ☐ Breast Lump
- ☐ Breast or Nipple Discharge
- ☐ Breast Pain
- ☐ Bruise Easily
- ☐ Change in Appetite
- ☐ Change in Bowel Habits
- ☐ Change in Hair Growth, Loss, Texture
- ☐ Change in Hearing
- ☐ Change in Moles/Freckles
- ☐ Change in Vision
- ☐ Chest Pain
- ☐ Chills
- ☐ Cold or Heat Intolerance
- ☐ Constipation
- ☐ Diarrhea
- ☐ Cough
- ☐ Dark or Bloody Stool
- ☐ Dizziness
- ☐ Douching
- ☐ Dry Mouth
- ☐ Excessive Thirst/Urination
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Increased Vaginal Discharge
- ☐ Indigestion
- ☐ Joint Pain, Stiffness, Swelling
- ☐ Loss of Consciousness
- ☐ Memory Change
- ☐ Mood Swings
- ☐ Nausea/Vomiting
- ☐ Nodules
- ☐ Nose Bleeds
- ☐ Numbness or Tingling
- ☐ Painful Urination
- ☐ Palpitations
- ☐ Pelvic Pain
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Sweat
- ☐ Swollen Lymph Nodes
- ☐ Tremors
- ☐ Unpleasant Vaginal Odor
- ☐ Urinary Urgency
- ☐ Urinating Frequently at Night
- ☐ Vaginal Bleeding (Unusual/Excessive)
- ☐ Vaginal Discharge that is Yellow-Green and Frothy
- ☐ Vaginal Discharge that is Thick, White and Cottage Cheese Like
- ☐ Vaginal Discharge that is Thin, Milky White or Gray
- ☐ Vaginal Itching or Burning
- ☐ Weakness
- ☐ Weight Gain (Recent)
- ☐ Weight Loss (Recent)
- ☐ Wheezing
- ☐ NONE OF THE ABOVE