ST. GEORGE OB/GYN **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):**

ST. GEORGE OB/GYN

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

ST. GEORGE OB/GYN

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	PERSCRIBING DOCTOR

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: _____ ☐Unknown ☐Never	RH Negative ☐**Yes** ☐**No**
	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: Full term (37-40 weeks): _____ Premature: _____ Miscarriages: _____ Abortions: _____ Ectopic Pregnancies: _____ Multiple Births: _____	Have you experienced pain with intercourse? ☐**Yes** ☐**No**
	Have you recently had sex with a new partner? ☐**Yes** ☐**No**
	Have you ever had intercourse against your will? ☐**Yes** ☐**No**
	Have you previously or currently been abused by your partner? ☐**Yes** ☐**No**
	Do you do monthly breast exams? ☐**Yes** ☐**No**
	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