OB/GYN ASSOCIATES OF WNY

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Account#______________________

PATIENT REGISTRATION (Please print clearly)

PATIENT INFORMATION:

Name:____ Date of Birth: _________________________

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 #______________________

OB/GYN ASSOCIATES OF WNY **Patient History Form**

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Name:____ Date:__________________

Date of Birth:___________________ Age:___________

First day of last menstrual period:__________________ Primary Care Physician:__________________________

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Briefly state the reason for your visit:____

____

List any allergies to medications:____

Age of first period:_______________ How many days does your period last?______________

How many days between periods?__________ Do they vary a lot?___________ Age of menopause:_______________

Have you ever had a venereal disease?____

Did your mother take DES (Diethylstilbestro?)____

Are you currently doing anything to prevent pregnancy?_________ If so, what?____________________________

Have you ever had an abnormal pap smear?__________________

If yes, what was the course treatment?____

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HOSPITALIZATIONS/SURGERIES

Year	Type of Surgery/Hospitalization	Reason	Doctor

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CURRENT MEDICATIONS

Name	Dosage	Doctor

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OTHER PHYSICIANS YOU CURRENTLY SEE

Name	Specialty	Doctor

Account #______________________

WOMEN'S HEALTH HISTORY

Last Pap Smear:____ Result:____

Last Mammogram:______________________________________ Result:____

Last Bone Density:______________________________________ Result:____

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PAST MEDICAL HISTORY

Check if YES:

________Measles
________Mumps
________German Measles
________Chicken Pox
________Scarlet Fever
________Rheumatic Fever
________Diabetes
________Glaucoma
________Hepatitis
________Anemia
________High Blood Pressure
________Heart Murmur
________Heart Disease
________Palpitations
________Shortness of Breath
________Chest Pains
________Drug Abuse

________Thyroid Problems
________Allergies
________Asthma
________Emphysema
________Ulcer
________Gallbladder Disease
________Bowel Problems
________Constipation
________Bleeding
________Diarrhea
________Anxiety/Nervousness
________Depression/Mental
________Gout
________Kidney/Urinary
________Cancer:________________________
________HIV/AIDS
________Alcohol Related Illness

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SOCIAL HISTORY

Marital Status:__________________________________

Occupation:_____________________________________

Alcohol use: Amount________________________
Frequency______________________

Tobacco use: How much per day?_______________
Years Smoking:_________________
Date Quit:______________________

Religion:_______________________

Exercise:_______________________

Hours of Sleep:_________________

Special Diet:____________________________

Hobbies:____

Coffee: (cups per day)____________________

Recent Travel Outside USA:_______________________

Account #______________________

FAMILY HISTORY

	Current Age	Major Illness	Cause of Death
Mother:			
Father:			
Brother:			
Sister:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			
Aunts/Uncles:			

Has anyone in your family ever been diagnosed with breast, ovarian, or colon cancer?____

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OBSTETRICAL HISTORY

Date	Full Term?	Sex	Weight	Hrs in Labor	Anesthesia	Problems

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NOTES/COMMENTS

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______________________________________ ______________________________

(Signature of Reviewing Physician) **(Date)**