PATIENT REGISTRATION FORM

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)		
Date of Birth (MM/DD/YYYY)	Social Security Number	Marital Status	Ethnicity (circle one) Hispanic/Latino Non-Hispanic/Latino	Race
Patient's Street Address	City	State	Zip	
Primary Phone: Home / Cell	Alternate Phone: Home / Cell	Email		
Preferred Contact Method: (circle one) Phone Email	Primary Care Physician Name	Primary Care Physician Phone		
Referred by	Pharmacy Name	Pharmacy Address	Pharmacy Phone	

Patient Employment Information

Employment Status (circle one) Employed Unemployed Retired Student	Employer Name	
Occupation	Employer Phone	Work Schedule (circle one) Full Time Part Time

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone: Home / Cell / Work	Relationship to Patient

Insurance and Billing

Primary Health Insurance

Insurance Company		Plan	
Plan / Policy Number	Group Number	Policy Holder's Employer	
Policy Holder's Name (as it appears on insurance card or ID)	Policy Holder's Social Security Number	Policy Holder's Date of Birth (MM/DD/YYYY)	
Policy Holder's Street Address	City	State	Zip
Policy Holder's Phone Number	Relationship to Policy Holder		

Secondary Health Insurance

Insurance Company		Plan	
Plan / Policy Number	Group Number	Policy Holder's Employer	
Policy Holder's Name (as it appears on insurance card or ID)	Policy Holder's Social Security Number	Policy Holder's Date of Birth (MM/DD/YYYY)	
Policy Holder's Phone Number	Relationship to Policy Holder		

Responsible Party

Billing Name (if other than patient)	Phone	Relationship to Patient	
Street Address	City	State	Zip

Signature

Signature of person completing form: _____ Date: _____

Patient Last Name _____ **DOB** _____

Patient History

Current Medications / Vitamins

What medications and / or vitamins are you currently taking?

Name of Medication / Vitamins	Dosage	Frequency

Allergies or Adverse Reactions

Do you have any allergies or any adverse reactions to drugs?

Allergen / Allergic Substance	Reaction

Hospitalizations & Surgeries

Please list all surgeries:

Reason	Date

Reason	Date

Past Medical History

Have you ever been diagnosed with any of the following?

☐ AIDS / HIV	☐ Auto Immune Disorder	☐ Cancer	☐ Heart Disease	☐ Infertility	☐ Trauma / Abuse
☐ Anemia	☐ Blood Disorder	☐ Diabetes	☐ Hepatitis	☐ Kidney / Bladder Disorder	☐ Urinary Tract Infection
☐ Arthritis	☐ Blood Transfusion	☐ Endometriosis	☐ High Blood Pressure	☐ Seizures	☐ Uterine Fibroids
☐ Asthma	☐ Bone Fracture	☐ Gastric Disorder	☐ High Cholesterol	☐ Thyroid - Hyper / Hypo	

If you have had cancer, please list type and current diagnosis: _____

Have you ever been diagnosed with any of the following sexually transmitted diseases (STDs)?

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Syphilis ☐ Trichomoniasis

Exams & Tests

	Results		If results were abnormal, please explain:
Last Pap Smear			
Year _____	☐ Normal	☐ Abnormal	_____
Last Mammogram			
Year _____	☐ Normal	☐ Abnormal	_____
Last Colonoscopy			
Year _____	☐ Normal	☐ Abnormal	_____
Last Dexa / Bone Density			
Year _____	☐ Normal	☐ Abnormal	_____

Patient Last Name _____ **DOB** _____

Family Medical History

Has anyone in your family ever been diagnosed with any of the following conditions?

☐ Breast Cancer ☐ Diabetes ☐ Gynecologic Cancer ☐ High Blood Pressure ☐ Stroke
☐ Colon Cancer ☐ Genetic Disorder ☐ Heart Disease ☐ Other Cancer: _____

Menstrual History & Pregnancy Details

Menstrual History

Last menstrual period:

Date _____

How long does your period last?

Days _____

How long between periods?

Days / weeks _____

Menstrual flow

☐ Light ☐ Moderate ☐ Heavy

Pain / Cramps with period?

☐ Yes ☐ No

Breakthrough spotting?

☐ Yes ☐ No

Are you in menopause?

☐ Yes ☐ No

Age at menopause:

_____

Currently on hormone replacement therapy?

☐ Yes ☐ No

Sexual Activity

Are you sexually active?

☐ Yes ☐ No

Pain / Bleeding after sex?

☐ Yes ☐ No

Do you practice safe sex?

☐ Yes ☐ No

If you practice safe sex, what birth control method do you use?

Type / Brand _____

Pregnancy Details

Are you pregnant or suspect you may be pregnant?

☐ Yes ☐ No

Are you planning a pregnancy?

☐ Yes ☐ No

Pregnancies

Total # Pregnancies	# Full Term	# Preterm	# Ectopic	# Elective Abortions	# Spontaneous Abortions

Births

Date	Birth Weight	Sex	Type of Delivery	Complications	Location

Patient Last Name _____ **DOB** _____

Lifestyle Factors

Smoking / Drug Use

Have you ever smoked / vaped?

☐ Yes ☐ No Number of years _____ Number of packs / cartridges per day _____

Do you smoke / vape now?

☐ Yes ☐ No Number of years _____ Number of packs / cartridges per day _____

Do you use recreational drugs?

☐ Yes ☐ No Types _____ Number of times / week _____

Alcohol / Caffeine

How much alcohol do you drink per week?

Number of drinks / week _____

How much caffeine do you drink per day?

Number of drinks / day _____

Exercise

How often do you exercise?

☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

If you do exercise, what type(s) of exercise do you engage in?

_____

Additional Items

Do you have any religious or cultural beliefs / values we should be aware of as we provide your care?

☐ Yes ☐ No

If yes, please explain: _____

Signature

Signature of person completing form

_____

Date

_____

Relationship (if other than patient)

_____