

Patient Registration Form *LifeCycles* OB GYN LLC

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Primary Care Physician Phone		
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone			
Employer/School Address	City	State	Zip		

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number		
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number		
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number		

Responsible Party

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

Signature of Patient or Authorized Guardian

Date

Name _____

Gender _____

Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today ?

How is your general health ?

Excellent Good Fair Poor

Do you have any other concerns you would like to address ?

Current Medications

What medications are you currently taking ?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any of the following ?

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Local Anesthetics |

Do you have any other allergies ?

Name	Reaction
_____	_____
_____	_____

Past Medical History

- | | | | | | |
|---|--|--|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke | |

Hospitalizations & Surgeries

Reason	Date
_____	_____
_____	_____

Lifestyle Factors

Are you sexually active ?

Yes No # of partners in past year _____

Do you wish to be checked for STDs ?

Yes No

Has anyone in your home ever physically or verbally hurt you ?

Yes No

Have you ever smoked ?

Yes No # of years _____ # packs/day _____

Do you smoke now ?

Yes No # packs/day _____

Do you use recreational drugs ?

Yes No types ? _____ # times/week _____

How much alcohol do you drink per week ?

drinks/week _____

How much caffeine do you drink per day ?

drinks/day _____

How often do you exercise ?

times/week _____

Family History

Has anyone in your family ever had any of the following conditions ?

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |

Details:

Name _____

Gender _____

Age _____

Date of Appointment: _____

OBGYN History

Have you ever had or do you currently have any of the following ?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abnormal Vaginal Bleeding | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Bleeding between Periods | <input type="checkbox"/> Cryosurgery | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> DES Exposure | <input type="checkbox"/> HPV | <input type="checkbox"/> Vkr'oi"Otägsgzux" Joykgyk |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Extreme Menstrual Pain | <input type="checkbox"/> Infertility | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Irregular Periods/Bleeding | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Nipple Discharge | <input type="checkbox"/> Yeast Infections - Frequent |

Pregnancy History

Please describe any pregnancies you have had.

_____	_____	_____	_____
# of Pregnancies	# of Full Term	# of Miscarriages	# of Abortions

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Were there any complications associated with any of your pregnancies ?

Are you currently pregnant ?

- Yes No

Are you trying to become pregnant ?

- Yes No

Do you need birth control or contraceptive advice ?

- Yes No

What method of birth control do you use ?

Menstrual History

When was the first day of your last period ?

How often does your period occur ?

How long does your period last ?

Is your period regular ?

- Yes No

What age were you when you had your first period ?

What age were you at menopause ?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
<input type="checkbox"/> Blood Sugar-Fasting	_____	_____
<input type="checkbox"/> Breast Self Exam	_____	_____
<input type="checkbox"/> Cholesterol Test	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> CT/CAT Scan	_____	_____
<input type="checkbox"/> Dexascan (Bone Density)	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____
<input type="checkbox"/> Fecal Occult Blood Test	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> Pap Smear	_____	_____
<input type="checkbox"/> Physical Exam	_____	_____
<input type="checkbox"/> Cardiac Stress Test	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____

Name _____

Gender _____

Age _____

Date of Appointment: _____

Review of Systems

General

- Chills
- Dizziness
- Fainting
- Fever
- Hair Loss
- Hair Growth - Excessive
- Night Sweats
- Sleeping Problems
- Thirst - Excessive
- Weight Gain
- Weight Loss

Mental Health

- Anxiety
- Depression
- Loss of Interest
- Feeling Hopeless
- Hearing Voices
- Marital Problems
- Panic Attacks
- Trouble Concentrating
- Suicide -Thoughts / Attempts

Musculoskeletal

- Back Pain
- Carpal Tunnel Syndrome
- Joint Pain
- Joint Swelling
- Neck Pain
- Shoulder Pain

Gastrointestinal

- Appetite Gain
- Appetite Loss
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Intestinal Disorder
- Lactose Intolerance
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Lack of Bladder Control
- Frequent Urination
- Painful Urination

Respiratory

- Coughing
- Coughing Up Blood
- Shortness of Breath
- Wheezing

ENT

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Jolāi{rz"}grruotm
- Double Vision
- Earaches
- Ear Discharge
- Hay Fever
- Hoarseness
- Hearing Loss
- Nose-Bleeds
- Persistent Cough
- Persistent Runny Nose
- Recurring Sore Throat
- Ringing in Ears
- Sinus Problems
- Vision Halos

Cardiovascular

- Chest Pains
- Irregular Heart Beat
- Circulation Problems
- Heart Palpitations
- Rapid Heartbeat
- Swelling of Ankles
- Varicose Veins

Skin

- Acne
- Bruise Easily
- Changes in Moles
- Chills
- Dry / Sensitive Skin
- Eczema
- Hives
- Itching
- Rash
- Scars
- Sores That Won't Heal

Neurological

- Coordination Problems
- Convulsions
- Jolāi{rz"}jgrqotm
- Learning Disabilities
- Light-headedness
- Memory Loss
- Numbness / Tingling
- Paralysis
- Seizures
- Speech Problems
- Tremors

Other Symptoms

Immunizations

Please check and date all immunizations you have had.

- | | |
|--|--------------------|
| <input type="checkbox"/> Hepatitis A | Month & Year _____ |
| <input type="checkbox"/> Hepatitis B (Series of 3) | Month & Year _____ |
| <input type="checkbox"/> HPV Vaccine | Month & Year _____ |
| <input type="checkbox"/> Influenza (Flu Shot) | Month & Year _____ |
| <input type="checkbox"/> Meningitis | Month & Year _____ |

- | | |
|---|--------------------|
| <input type="checkbox"/> MMR
(Measles, Mumps, Rubella) | Month & Year _____ |
| <input type="checkbox"/> Pneumonia | Month & Year _____ |
| <input type="checkbox"/> Polio | Month & Year _____ |
| <input type="checkbox"/> Tetanus | Month & Year _____ |