W I L S O N
OB-GYN

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: ______________________ Date of Birth: ____________ Age: ______

SSN: ______________ Race: __________ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Home Address: ______________________ City, State & Zip Code: ______________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email Address: ______________________ Employer: ______________________

Primary Care Physician: ______________________ Primary Care Address: ______________________

Preferred Pharmacy: ______________________ Pharmacy Address: ______________________

POLICYHOLDERS INFORMATION (If different from patient)

Name: ______________________ Date of Birth: ______________________

SSN: ______________________ Relationship to Insured: ☐Spouse ☐Parent/Guardian

PRIVACY INFORMATION (HIPAA)

I authorize Wilson OB-GYN to contact me and/or to leave messages in the following ways:

☐Home Phone ☐Work Phone ☐Cell Phone ☐E-mail

I authorize Wilson OB-GYN to release my medical information to the named person(s) listed below:

☐Spouse/Parents/Children: ____

☐Other (Relationship to the Patient)____

OFFICE POLICY

- LATE – If you arrive more than 15 minutes late for your appointment you may be asked to reschedule.
- PRESCRIPTION REFILLS – Call your pharmacy and ask them to **fax a refill request to our office.** DO NOT wait until you are out of your medicine. Refill requests take 24-48 hours.
- FORMS – FMLA forms requiring medical review and physician signature will be completed within 7-10 business days with a fee of $20. Please allow plenty of time for completion.
- PATIENT CONFIDENTIALITY – In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), a copy of the Wilson OB-GYN Notice of Privacy Practices is available to all patients in the office or online at www.wilsonobgyn.com.

READ & SIGN BELOW

I certify that the information provided is correct and complete to the best of my knowledge. I have read, understand and agree to the above Office Policy.

______________________________ ______________________
Signature of Patient (or Legal Guardian) Date

Name: ______________________ Date: ______________

MEDICAL HISTORY FORM

In your own words, please write the nature of the medical problem for which you are being seen.

____

____

____

Medical Problems/Illnesses

*Do you have any of the following?

Condition	Yes	No
Glaucoma	□Yes	□No
Kidney Disease	□Yes	□No
Recurrent Bladder Infections (UTI's)	□Yes	□No
Heart Problems	□Yes	□No
Blood clots/DVT	□Yes	□No
Hypertension	□Yes	□No
Bleeding Disorder	□Yes	□No
High Cholesterol	□Yes	□No
Liver Disease	□Yes	□No
Fibroids	□Yes	□No
Anxiety/Depression	□Yes	□No
Asthma	□Yes	□No
Ovarian Cysts	□Yes	□No
GERD/Ulcers	□Yes	□No
Hepatitis	□Yes	□No
Diabetes	□Yes	□No
Thyroid Disease	□Yes	□No
Osteoporosis/penia	□Yes	□No
Seizures/Epilepsy	□Yes	□No
Stroke	□Yes	□No
Migraine Headaches	□Yes	□No
Anemia	□Yes	□No
Blood Transfusion	□Yes	□No
Cancer ,Type:__________	□Yes	□No
Lupus	□Yes	□No
HIV/AIDS	□Yes	□No
Gonorrhea/Chlamydia	□Yes	□No
Lung Disease	□Yes	□No
Syphilis	□Yes	□No

Other:______________________

Medications

____
____
____
____
____
____
____
____
____
____
____
____

Allergies

Medications	Reactions
______________	__________
______________	__________
______________	__________

Social History/Habits

*Do you use?

Substance	Yes	No	
Alcohol	□Yes	□No	Drinks per week: _____
Tobacco	□Yes	□No	Packs per day: _____
Illicit Drugs	□Yes	□No	Type: ____________

Name: ______________________________ Date: ________________

Family History

Any history of the below conditions in your family?

Ovarian Cancer	Who______________	Pancreatic Cancer	Who___________
Uterine Cancer	Who______________	Diabetes	Who___________
Endometrial Cancer	Who______________	Stroke/Blood Clots	Who___________
Cervical Cancer	Who______________	Bleeding Disorders	Who___________
Vaginal Cancer	Who______________	Colon Cancer	Who___________
Breast Cancer	Who______________		

Surgeries

Surgery	Reason	Year	Hospital

Obstetrics/Gynecologic History

Age of First Period ____________

Age of Last Period ____________(if postmenopausal)

Cycle Length ______days between each period

Period Length ______days of bleeding

First day of last period____________

Last Pap Smear ____________

Last DEXA ____________

Number of Pregnancies _________

Number of Miscarriages _________

Number of Terminations _________

Ectopic Pregnancies _________

Number of living children _________

Last Mammogram _________

Last Colonoscopy _________

Did you receive Gardasil (HPV) Vaccine ☐Yes ☐No ☐Unsure

Current Contraception (birth control) ________________________________

Including permanent sterilization

Delivery History

Date of Birth (M/D/YY)	Full Term(over 37 weeks) Or Preterm	Type of Delivery (Vaginal or C-section)	Complications	Weight	Boy/Girl

*Please indicate for each pregnancy whether spinal, IV Medications, Epidural, or None