



OB 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 (HIPAA), 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 reason for which you are being seen.

Medical Problems/Illnesses

Medications

*Do you have any of the following?

- 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: _____

Allergies

Medications	Reactions
_____	_____
_____	_____
_____	_____

Social History/Habits

*Do you use?

- 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? Please list relationship in space below.

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

Surgeries

Surgery	Reason	Year	Hospital

Obstetrics/Gynecologic History

Age of First Period	_____	Number of Pregnancies	_____
Age of Last Period	_____ (if postmenopausal)	Number of Miscarriages	_____
Cycle Length	_____ days between each period	Number of Terminations	_____
Period Length	_____ days of bleeding	Ectopic Pregnancies	_____
First day of last period	_____	Number of living children	_____
Last Pap Smear	_____	Last Mammogram	_____
Last DEXA	_____	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