PRINEGynecology

Welcome to PRINE Health Medical Group, PLLC.

PATIENT REGISTRATION FORM

<table>
<tr><td colspan="2">Today's Date:</td><td>Age:</td><td>Thank you for choosing PRINE Health Medical Group</td></tr>
<tr><td colspan="4">PATIENT INFORMATION</td></tr>
<tr><td>Last Name:</td><td colspan="2">First Name:</td><td>Middle:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">SSN:</td></tr>
<tr><td colspan="4">Street Address:</td></tr>
<tr><td colspan="4">City, State, Zip:</td></tr>
<tr><td>Home Phone Number:</td><td colspan="2">Mobile:</td><td>Work:</td></tr>
<tr><td colspan="2">Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Other:</td><td colspan="2">Preferred Language: ☐ English ☐ Other ________________</td></tr>
<tr><td colspan="2">E-mail:</td><td colspan="2"></td></tr>
<tr><td colspan="2" rowspan="2">Is it ok to leave a detailed message? (Please check one of the following)
☐ YES, it is ok to leave a detailed message at the following number (______)____________________
☐ NO, please do not leave detailed messages.</td><td colspan="2">Referred By:</td></tr>
<tr><td colspan="2">Reason for Today's Visit:</td></tr>
<tr><td colspan="4">EMERGENCY CONTACT</td></tr>
<tr><td colspan="2">Name of person:</td><td colspan="2">Relation:</td></tr>
<tr><td colspan="2">Phone Number:</td><td colspan="2">Additional Contact Number:</td></tr>
</table>

PRIMARY INSURANCE INFORMATION		
Insurance Carrier:	**Policy ID:**	**Insurance Phone Number:**
Policy Holder:	**Date of Birth:**	**Relationship to Patient:**

SECONDARY INSURANCE INFORMATION (If Applicable)		
Insurance Carrier:	**Policy ID:**	**Insurance Phone Number:**
Policy Holder:	**Date of Birth:**	**Relationship to Patient:**

PHARMACY INFORMATION (*Please list both)*			
	Name	**Phone Number**	**Address**
Local:			
Mail-Away:			

Please list all the medications you take (include Name, Dose, and Frequency):

____

____

____

____

☐ None

Please list all medications that you are allergic to:

____

____

____

____

☐ None

Please list *ALL* surgeries that you have had:

____

____

____

____

☐ None

OBSTETRICAL HISTORY
Total Number of Pregnancies:
Number of Abortions/Terminations:
Number of Miscarriages:
Number of Ectopic Pregnancies:
Total Number of Births (please elaborate below):

Births	Year	Full Term or Preterm?	Vaginal Delivery or C-Section?	Complications?
1st				
2nd				
3rd				
4th				
5th				

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GYNECOLOGICAL HISTORY				
Do you have/have you ever had any of the following gynecologic conditions:				
Fibroids?	☐ YES	☐ NO		
Ovarian Cysts Requiring Surgery?	☐ YES	☐ NO		
Endometriosis?	☐ YES	☐ NO		
Abnormal PAPs/HPV?	☐ YES	☐ NO		
Sexually Transmitted Infections (Gonorrhea, Chlamydia, Herpes, Syphilis, Trichomonas, HIV/AIDS, genital warts, Molluscum contagiosum)	☐ YES	☐ NO		
Recurrent Vaginal Infections (BV, yeast, etc.)	☐ YES	☐ NO		
When was your last PAP smear?				
When was your last Mammogram?				
When did your last menstrual period start?				
Have you ever had sex?	☐ YES	☐ NO (Skip to next page)		
Are you/have you been sexually active with:	☐ Males	☐ Females	☐ Both	☐ Other
Are you currently sexually active?	☐ YES	☐ NO (Skip to next page)		

If sexually active with males, what is your form of pregnancy protection?

☐ **Condoms**

☐ **Withdrawal/Pull-Out**

☐ **Birth Control Pills, Patch, or Ring (Name the one you use)**_____________________________________

☐ **Depo-Provera**

☐ **Nexplanon (arm implant)**

☐ **IUD (Name the one you use)**____

☐ **Sterilization** ☐ **Male** ☐ **Female**

☐ **None**

MEDICAL HISTORY					
Medical Problem	**YES**	**NO**	**Medical Problem**	**YES**	**NO**
Anemia	☐	☐	**Hepatitis**	☐	☐
Arthritis	☐	☐	**HIV/AIDS**	☐	☐
Asthma	☐	☐	**High Cholesterol/Hypercholesterolemia**	☐	☐
Breast Issues	☐	☐	**High Blood Pressure/Hypertension**	☐	☐
Blood Clots (DVTs or PEs)	☐	☐	**Kidney Disease**	☐	☐
Cancer (If so, location (s)?)	☐	☐	**Migraines**	☐	☐
COPD	☐	☐	**Psychiatric Issues (Depression, anxiety, bipolar, schizophrenia, others)**	☐	☐
Diabetes	☐	☐	**Stroke/TIA**	☐	☐
Genetic or Chromosomal Disorders	☐	☐	**Thyroid Issues**	☐	☐
Heart Attack	☐	☐	**Other**	☐	☐
Heart Disease	☐	☐			

SOCIAL HISTORY			
	Tobacco	**Alcohol**	**Drugs**
Type:			
Frequency and Amount:			
Length of Usage:			

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Name ___________________________________ Today's Date ___________________

DOB ____________________________________

Please answer the following questions to the best of your ability. Circle **YES** for any of the cancers in your family.

The Following Relatives Should Be Considered: 1st degree-Mother, Father, Brother, Sister, Children 2nd degree-Paternal and Maternal Aunts/Uncles, Half Siblings, Nieces/Nephews, Paternal and Maternal Grandparents 3rd degree-1st Cousins, Great Aunts/Uncles, Great Grandparents

Cancer History Description	**Circle**	**Yourself/Relative**	**Paternal/Maternal**	**Ages**
Breast Cancer diagnosed at or before age 50 (First Second degree)	**Yes** **No**			
Ovarian Cancer (First Second degree)	**Yes** **No**			
Male Breast Cancer (First Second degree)	**Yes** **No**			
Pancreatic Cancer (First Second degree)	**Yes** **No**			
Metastatic Prostate Cancer (First Second degree)	**Yes** **No**			
Three or more of the following on same side of the family: prostate, pancreatic or breast (First Second and Third degree)	**Yes** **No**			
Any relative diagnosed twice or in both breasts (First Second degree)	**Yes** **No**			
Are you Ashkenazzi Jewish and have a diagnosis of breast, ovarian, or pancreatic cancer in any family members listed above at any age (circle the cancer)	**Yes** **No**			
Colon cancer before age 50 (First Second and Third degree)	**Yes** **No**			
Uterine/Endometrial cancer before age 50	**Yes** **No**			
Three or more of the following: colon, endometrial, stomach, small bowel, renal, brain, sebaceous adenoma	**Yes** **No**			

Have you or any of your family member been tested for the BRCA gene? ____

If your family history does not match the above criteria, check here _________