Saratoga OB/GYN at Myrtle Street

PATIENT REGISTRATION

FIRST NAME (LEGAL)	PREFERRED FIRST NAME	MI	LAST NAME

STREET ADDRESS	CITY	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

EMAIL ADDRESS	DATE OF BIRTH

RACE (please circle one)	ETHNICITY (please circle one)	LANGUAGE PREFERENCE (please circle one)	GENDER
WHITE BLACK AMERICAN INDIAN ASIAN OTHER _____	HISPANIC ORIGIN NOT OF HISPANIC ORIGIN OTHER _____	ENGLISH OTHER _____	_____

PHARMACY	REFERRING DOCTOR	PRIMARY DOCTOR

RELATIONSHIP STATUS (please circle one)	EMPLOYER
NEVER MARRIED MARRIED DIVORCED SEPARATED DOMESTIC PARTNER WIDOWED OTHER _____	

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME

INSURANCE COMPANY ADDRESS

NAME OF INSURANCE POLICY HOLDER	INSURED'S DATE OF BIRTH

INSURANCE GROUP #	INSURED'S POLICY #	PATIENT INSURANCE POLICY #

INSURED'S EMPLOYER	EMPLOYER'S ADDRESS

RELATIONSHIP TO INSURED	EFFECTIVE DATE OF INSURANCE PLAN	IF AUTO OR WORK RELATED, DATE OF INJURY

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME

INSURANCE COMPANY ADDRESS

NAME OF INSURANCE POLICY HOLDER	INSURED'S DATE OF BIRTH

INSURANCE GROUP #	INSURED'S POLICY #	PATIENT INSURANCE POLICY #

INSURED'S EMPLOYER	EMPLOYER'S ADDRESS

RELATIONSHIP TO INSURED	EFFECTIVE DATE OF INSURANCE PLAN	IF AUTO OR WORK RELATED, DATE OF INJURY

HOW DID YOU HEAR ABOUT US? ☐ FRIEND/RELATIVE ☐ PHONE BOOK ☐ MAGAZINE AD ☐ INTERNET ☐ OTHER

PLEASE SPECIFY: _____

SARATOGA OB/GYN
AT MYRTLE STREET
A SERVICE OF SARATOGA REGIONAL MEDICAL, P.C.
AN AFFILIATE OF SARATOGA HOSPITAL

TODAY'S DATE: _____ **APPOINTMENT DATE:** _____

PATIENT LEGAL NAME: _____ **DATE OF BIRTH:** _____

PREFERRED NAME: _____ **GENDER:** _____

PRIMARY CARE PHYSICIAN: _____ **PHARMACY AND LOCATION:** _____

REASON FOR VISIT: _____

CURRENT MEDICATIONS AND DOSAGE (including vitamins and over-the-counter): _____

_____

_____

_____

ALLERGIES (and type of reaction): _____

_____

Do you have any chronic illnesses? Yes___ No___ If yes, please list: _____

_____

_____

OB/GYN HISTORY (please answer all questions that apply to you)

Age at first menstrual period:	Any vaginal itching or burning?	Are you sexually active?
First day of last period:	Have you had the HPV/Gardasil vaccine	Is intercourse painful?
How many days does period last?	Series? If yes, how many shots?	Total # of sexual partners in lifetime:
How many days between periods?	Have you ever had an abnormal pap or	# of male partners:
Is your flow heavy, light, moderate?	procedure (i.e. colposcopy, LEEP) on	# of female partners:
Are your periods painful?	your cervix? If yes, describe.	Sexual orientation:
Other menstrual symptoms:		Straight/Heterosexual Gay/Lesbian/Homosexual Other (please specify):
Do you have any history of sexually transmitted disease? If yes, describe.		

SELF CARE

Do you have regular check ups?	Date of last pelvic/pap exam:	Date of last colonoscopy:
Date of last breast exam:	Date of last mammogram:	Other testing:
Do you do self breast exams?	Date of last bone density scan:	Current birth control method:

MENOPAUSE HISTORY (Please answer all questions that apply to you.)

Age at menopause:	Are you currently or have you ever taken hormones?
Symptoms of menopause:	If yes, what?
	If yes, when and for how long?
If you have had a hysterectomy, do you still have your ovaries?	Are there any side effects?

PREGNANCY HISTORY **Are you currently pregnant?**

Total # of Pregnancies:	**# of Premature Births:**	**# of Miscarriages:**	**# of Induced Abortions:**	**# of Living Children:**

Date of birth	Weeks at delivery (Term = 40)	Baby's sex	Weight at birth	Hours in Labor	Type of Delivery	Type of Anesthesia	Hospital & Name of MD or CNM	Baby's Name	Complications

Patient Name: _____

PLEASE CHECK ALL CHILDHOOD ILLNESSES OR MEDICAL PROBLEMS YOU HAVE HAD:
Please check box to **LEFT** of illness or problem.

	Abdominal Aortic Aneurysm
	Abnormal Pap smear
	Acne
	ADHD
	AIDS
	Alcoholism
	Seasonal Allergies
	Alzheimer's Disease
	Anemia
	Angina
	Arteriosclerosis
	Arthritis, Rheumatoid
	Arthritis, Osteo
	Asthma
	Atrial Fibrillation
	Bladder Infections
	Blood Transfusions
	Bronchitis
	Cancer
	Carotid Artery Stenosis
	Cataracts
	Cerebrovascular Accident (CVA)
	Chickenpox
	Chickenpox - Vaccine
	Cirrhosis
	CNS Tumors
	Colitis
	Colon Polyps
	Congestive Heart Failure
	COPD
	Coronary Artery Disease
	Crohn’s Disease
	Depression
	Dermatitis
	Diabetes- Insulin Dependent
	Diabetes- Non Insulin Dependent
	Diverticulitis
	Diverticulosis

	Drug Addiction
	Eating Disorder
	Emphysema
	Epilepsy
	Esophagitis
	Fibrocystic Disease of Breast
	Fibromyalgia
	GERD
	Gallstones
	Glaucoma
	Gonorrhea
	Gout
	Hard of Hearing
	Headache
	Heart Attack (MI)
	Heart Disease
	Heart Failure
	Heart Murmur
	Hemophilia
	Hepatitis A
	Hepatitis B
	Hepatitis C
	Herpes
	Hiatal Hernia
	HIV
	Hodgkin's Disease
	Hypercholesterolemia
	Hypertension
	Incontinence
	Infertility
	Kidney Disease
	Kidney Infections
	Kidney Stones
	Leukemia
	Liver Disease
	Lung Disease
	Lupus

	Measles
	Mental Illness
	Migraine
	Mitral Valve Prolapse (MVP)
	Multiple Sclerosis (MS)
	Mumps
	Obesity
	Osteoporosis
	Peptic Ulcer Disease
	Palpitations
	Pancreatitis
	Parkinson's Disease
	Peripheral Vascular Disease
	Phlebitis
	Pneumonia
	Poliomyelitis
	Psoriasis
	Pulmonary Embolism
	Rheumatic Fever
	Rubella
	Scarlet Fever
	Scoliosis
	Seizure Disorder
	Sickle Cell Anemia
	Sinusitis
	Stroke
	Syphilis
	Transient Ischemic Attack (TIA)
	Thyroid Disease
	Hypothyroidism
	Hyperthyroidism
	Grave’s Disease
	Tuberculosis
	Tumors
	Ulcers
	Venous Insufficiency
	Vertigo

PLEASE LIST ANY OTHER CHILDHOOD ILLNESSES OR MEDICAL PROBLEMS:

List any assistive devices you wear or use, such as hearing aids, contact lenses, glasses, walkers:

_____

Patient Name: _____

SURGERIES, PROCEDURES AND HOSPITALIZATIONS (Please list all with dates.)

DATE	TYPE OF SURGERY	SURGEON	HOSPITAL	COMPLICATIONS
DATE	**TYPE OF PROCEDURE**	**PHYSICIAN**	**FACILITY**	**COMPLICATIONS**
DATE	**TYPE OF HOSPITALIZATION**	**PHYSICIAN**	**HOSPITAL**	**COMPLICATIONS**

FAMILY MEDICAL HISTORY (Please list all family illnesses.)

RELATIVE	**ILLNESSES & AGE AT DIAGNOSIS** (Breast Cancer, Uterine Cancer, Colon Cancer, Ovarian Cancer, Heart Disease, Diabetes, etc.)	**LIVING** (Yes /No) If no, age deceased
Father		
Mother		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Brothers # _____		
Sisters # _____		
Other (Children, Aunts, Uncles, Nieces, Nephews, Cousins)		
Are you of Ashkenazi Jewish descent?		

SOCIAL/PERSONAL HISTORY

Highest level of education attained: _____ Marital Status: _____

Occupation: _____ Are you currently working? Yes _____ No_____

Do you smoke? Yes____ No_____ If yes, # cigarettes per day: _____

If yes, how important is it for you to quit smoking? (Circle one) 1 2 3 4 5 6 7 8 9 10

If yes, how ready are you to quit smoking? (Circle one) 1 2 3 4 5 6 7 8 9 10

If no, did you previously smoke? Yes____ No_____ If yes, # cigarettes per day: _____

Do you drink alcohol? Yes____ No_____ If yes, # drinks per day: _____

Do you use street drugs? Yes____ No_____ If yes, type and how often: _____

Do you drink caffeine? Yes____ No_____ If yes, type and # cups per day: _____

Do you exercise? Yes____ No_____ If yes, type and how often: _____

_____

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NAME: _____ **DATE OF BIRTH:** _____ **APPOINTMENT DATE:** _____

OSTEOPOROSIS RISK SURVEY

Risk Factor Assessment

1.	Are you an Asian or Caucasian female?	YES	NO
2.	Do you have rheumatoid arthritis?	YES	NO
3.	Do you have a family history of osteoporosis?	YES	NO
4.	Do you have a personal history of fracture as an adult?	YES	NO
5.	Did you have surgically induced menopause or both ovaries removed before age 45?	YES	NO
6.	Do you suffer from irregular or missed periods (less than 4 periods per year) for one year or more?	YES	NO
7.	Do you smoke cigarettes?	YES	NO
8.	Do you have low body weight (less than 127 lbs)?	YES	NO
9.	Do you regularly consume dairy products in your diet?	YES	NO
10.	Do you consume more than 2 servings of alcohol daily?	YES	NO
11.	Do you exercise regularly?	YES	NO

Who Should Be Tested for Bone Mineral Density (BMD)?

1.	Are you a woman 65 years of age or older?	YES	NO
2.	Are you a postmenopausal woman under age 65 who has one or more additional risk factors (from section above) for osteoporosis?	YES	NO
3.	Have you been on hormone replacement therapy for prolonged periods (more than 3 months)?	YES	NO
4.	Have you taken steroids or glucocorticoid medications (prednisone, cortisone) to treat asthma, arthritis, lupus or other chronic diseases (3 consecutive months or more)?	YES	NO