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		Drug Addiction		Measles
	Abnormal Pap smear		Eating Disorder		Mental Illness
	Acne		Emphysema		Migraine
	ADHD		Epilepsy		Mitral Valve Prolapse (MVP)
	AIDS		Esophagitis		Multiple Sclerosis (MS)
	Alcoholism		Fibrocystic Disease of Breast		Mumps
	Seasonal Allergies		Fibromyalgia		Obesity
	Alzheimer's Disease		GERD		Osteoporosis
	Anemia		Gallstones		Peptic Ulcer Disease
	Angina		Glaucoma		Palpitations
	Arteriosclerosis		Gonorrhea		Pancreatitis
	Arthritis, Rheumatoid		Gout		Parkinson's Disease
	Arthritis, Osteo		Hard of Hearing		Peripheral Vascular Disease
	Asthma		Headache		Phlebitis
	Atrial Fibrillation		Heart Attack (MI)		Pneumonia
	Bladder Infections		Heart Disease		Poliomyelitis
	Blood Transfusions		Heart Failure		Psoriasis
	Bronchitis		Heart Murmur		Pulmonary Embolism
	Cancer		Hemophilia		Rheumatic Fever
	Carotid Artery Stenosis		Hepatitis A		Rubella
	Cataracts		Hepatitis B		Scarlet Fever
	Cerebrovascular Accident (CVA)		Hepatitis C		Seizure Disorder
	Chickenpox		Herpes		Sickle Cell Anemia
	Chickenpox - Vaccine		Hiatal Hernia		Sinusitis
	Cirrhosis		HIV		Stroke
	CNS Tumors		Hodgkin's Disease		Syphilis
	Colitis		Hypercholesterolemia		Transient Ischemic Attack
	Colon Polyps		Hypertension		Thyroid Disease
	Congestive Heart Failure		Incontinence		Hypothyroidism
	COPD		Infertility		Hyperthyroidism
	Coronary Artery Disease		Kidney Disease		Grave’s Disease
	Crohn’s Disease		Kidney Infections		Tuberculosis
	Depression		Kidney Stones		Tumors
	Dermatitis		Leukemia		Ulcers
	Diabetes- Insulin Dependent		Liver Disease		Venous Insufficiency
	Diabetes- Non Insulin Dependent		Lung Disease		Vertigo
	Diverticulitis		Lupus		
	Diverticulosis				

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: _____

_____

Patient Name:_____

OSTEOPOROSIS RISK SURVEY

Risk Factor Assessment

1. Are you an Asian or Caucasian female?	Yes	No
2. Do you have a family history of osteoporosis?	Yes	No
3. Do you have a personal history of fracture as an adult ?	Yes	No
4. Did you have surgically induced menopause or both ovaries removed before age 45?	Yes	No
5. Do you suffer from irregular or missed periods (for one year or more)?	Yes	No
6. Do you smoke cigarettes?	Yes	No
7. Do you have low body weight (less than 127 lbs)?	Yes	No
8. Have you had a lifelong low calcium intake?	Yes	No
9. Do you consume more than 2 servings of alcohol daily?	Yes	No
10. Are you getting little or no weight-bearing exercise?	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