

# Ladies First Health Care

## Registration Form

### PATIENT INFORMATION

NAME:	Last	First	M.I.
Date of Birth:	Have you ever been seen by a Doctor under a previous name? <input type="checkbox"/> NO <input type="checkbox"/> YES   If YES, please give previous name:		
Marital Status:	M   S   W   D	Email Address: <i>*for office use only we NEVER share your email*</i>	
Social Security Number:		Primary Care Physician/Location:	
Street Address:		City:	State:   Zip:
Phone:	Home	Cell	Work
Emergency Contact:	Name	Relation	Phone Number
If you are a dependent on your insurance policy please provide the name, date of birth and gender of the subscriber on the policy:			

### DEMOGRAPHICS

Gender:	Gender Identity:		
Preferred Languages:	Primary	Secondary	
Race: <i>*Check all that apply*</i>	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Specify		
Ethnicity:	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Specify		

### FOR OUR INFORMATION

What is your Preferred Pharmacy?	Name	Street/City
How did you hear about us?		
What is your preferred method of contact?	<input type="checkbox"/> Home Phone Call <input type="checkbox"/> Cell Phone Call <input type="checkbox"/> Mail <input type="checkbox"/> E-Mail/Patient Portal Messaging	
<i>Reminder calls/texts/emails are sent automatically from our system 1 week, 2 days and 90 minutes prior to appointments that have not been confirmed. A staff member will also call you 1 business day prior to your appointment if it has not been confirmed.</i>		
<b>Do you wish to opt out of automated calls/texts/emails?</b> YES   NO		

Please read, sign and date the reverse side of this form.

# Ladies First Health Care

## Health Questionnaire

### PATIENT INFORMATION

NAME: Last	First	M.I.
Date of Birth:	Age:	Primary Care Physician/Location:
Gender:	Gender Identity:	

### GYNECOLOGICAL HISTORY

Date of Last Menstrual Period (First Day):	Age Period Began:	Length of Periods:	Length of Cycles (time between periods):
Are you sexually active? <input type="checkbox"/> Yes, currently <input type="checkbox"/> Never <input type="checkbox"/> In the past but not now	Number of Sexual Partners: Lifetime	Currently	Gender of Sexual Partners: <i>*Circle All That Apply*</i> Female    Male Trans    Other: _____
What do you currently use for birth control:			
What have you used in the past for birth control:			
Date of Last Pap Smear:	Results:		
Date of Last Mammogram:	Results:		
Date of Last Colonoscopy:	Results:		

### Check any/all items below that you currently experience and/or have a history of:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Abnormal Pap                  | <input type="checkbox"/> Infertility      | <input type="checkbox"/> Hot Flashes     | <input type="checkbox"/> Pelvic Pain                |
| <input type="checkbox"/> Abnormal Periods              | <input type="checkbox"/> Endometriosis    | <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Nipple Discharge           |
| <input type="checkbox"/> STI's                         | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Mood Swings     | <input type="checkbox"/> Ovarian Cysts              |
| <input type="checkbox"/> PID                           | <input type="checkbox"/> Breast Disease   | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Pelvic or Bladder Prolapse |
| <input type="checkbox"/> Cervical cauterly or freezing | <input type="checkbox"/> Female Cancer(s) | <input type="checkbox"/> Night Sweats    | <input type="checkbox"/> Urinary Incontinence       |

### PREGNANCY HISTORY

Are you currently pregnant?	Are you trying to get pregnant?		
Number of: Pregnancies	Miscarriages	Abortions	
Please list each delivery: <i>*if you need more room, please use the space at the end of this packet*</i>			
<i>Type of Delivery (Vaginal or C-Section)</i>	<i>Year</i>	<i>Any Complications</i>	

# Ladies First Health Care

## Health Questionnaire

### MEDICAL HISTORY

**Do you experience:** *\*Check all that apply\**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Depression/Anxiety  | <input type="checkbox"/> Blood in Urine     | <input type="checkbox"/> Weight Loss     | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Sleep Interruptions | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Bowel Changes   | <input type="checkbox"/> Persistent Cough  |
| <input type="checkbox"/> Temp. Intolerances  | <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Sinus Problems    |
| <input type="checkbox"/> Fainting Spells     | <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Vomiting Blood  | <input type="checkbox"/> Easy Bruising     |

**Do you or have you ever had:** *\*Check all that apply\**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Urinary/Bowel Problems    |
| <input type="checkbox"/> Epilepsy/Seizures  | <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Psychological Issues | <input type="checkbox"/> Pulmonary Embolism        |
| <input type="checkbox"/> Lung Disease       | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> Arthritis/Back Problems   |
| <input type="checkbox"/> Varicose Veins     | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Gallbladder Disease  | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Lupus             | <input type="checkbox"/> Bleeding Problem     | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Sickle Cell Trait | <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Neuro. Disease (Aneurysm) |

Allergies:	
Allergen	Reaction

Medications:			
Medication	Dose	Medication	Dose

Surgeries: <i>*excluding deliveries listed on the previous page*</i>		
Procedure/Reason	Year	Facility

Please print your First and Last name and Date of Birth: \_\_\_\_\_  
*\*This ensures all pages are loaded to the correct patient\**

# Ladies First Health Care

## Health Questionnaire

### SOCIAL HISTORY

Who lives with you?			
Marital Status: M S W D		Family Problems? Y N	Spousal Problems? Y N
Occupation			
Occupational Concerns: <i>*Circle*</i> Stress Hazardous Substances Heavy Lifting Other _____			
Please tell us about your use of the following:			
Tobacco	<input type="checkbox"/> Current <input type="checkbox"/> Past	Type:	Amount: How Long:
Alcohol	<input type="checkbox"/> Current <input type="checkbox"/> Past	Type:	Amount: How Long:
Drugs	<input type="checkbox"/> Current <input type="checkbox"/> Past	Type:	Amount: How Long:
In the last 12 months have you had issues with any of the follow? <i>*Check all that apply*</i>			
<input type="checkbox"/> Having enough food for yourself/family <input type="checkbox"/> Homelessness/Housing <input type="checkbox"/> Transportation <input type="checkbox"/> Paying for Necessities (ie. Utilities, Diapers, Feminine Products, etc.) <input type="checkbox"/> Physical/Emotional/Sexual Abuse			
If so, would you like a referral to resources? Y N      What is your most urgent issue?			

### FAMILY HISTORY

Condition	Father	Mother	Mother's Parents	Father's Parents	Brothers/Sisters	Aunts/Uncles	Your Children
Heart Disease							
High Blood Pressure							
Stroke							
Diabetes							
Thyroid Disease							
Menopause Problems							
Mental Illness							
Cancer							

**Use this box to tell give details of the items you checked above, please make sure to list types of cancer and ages of diagnosis if known:**

Please print your First and Last name and Date of Birth: \_\_\_\_\_

*\*This ensures all pages are loaded to the correct patient\**

# Ladies First Health Care

## Health Questionnaire

**PHQ-9**

Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>*Circle*</i>				
	Not at all	Several days	More than half the days	Nearly every day
Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have notices. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you experienced any of the above, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<i>*For provider use*</i>			<b>TOTAL:</b>	

**Please use this space for anything you could not fit in the spaces provided or for any other pertinent issues/history you would like to discuss with your provider:**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please print your First and Last name and Date of Birth: \_\_\_\_\_  
*\*This ensures all pages are loaded to the correct patient\**