WOMEN'S HEALTH CARE GROUP OF PA
Main Line Perinatal Associates Division

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Patient Registration/Medical History

Please complete the following information as accurately as possible. Your answers on this form will help your physician understand your medical concerns better. If you cannot remember specific details, please give best estimates. We realize that this is a lengthy form, but we are asking you to provide a comprehensive history for us to improve your care.

Name: _____ DOB:_____ Date:_____

Marital Status: [] Single [] Married [] Divorced [] Domestic Partner SSN:_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Patient's Occupation: _____

Spouse's Name: _____ DOB: _____ Occupation: _____

Emergency Contact Name/Number: _____

Race: [] American Indian/Alaska Native [] White [] Asian [] Black/African American [] Pacific Islander [] Other

Ethnicity: [] Hispanic/Latino [] Non-Hispanic/Latino

Preferred Method of Communication: [] Phone [] Email [] Mail [] Text

Email: _____

Referring Physician: _____ Phone: _____ Fax: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Insurance Information

Primary Carrier: _____

ID number: _____ Effective Date: _____

Group/Plan #: _____ Subscriber's DOB, Sex: _____

Subscriber's Name: _____ Relationship to Patient: _____

Secondary Carrier: _____

ID number: _____ Effective Date: _____

Group/Plan #: _____ Subscriber's DOB, Sex: _____

Subscriber's Name: _____ Relationship to Patient: _____

Reason for visit: [ ] Preconception Consult [ ] Obstetric first visit [ ] Perinatal Consult

If you are here for a problem, what are your concerns? _____

Gynecology

1st day of your last menstrual period: _____

Was any fertility treatment required for this pregnancy? If so, what and who was your provider? _____

_____

What is your due date? _____

Last Pap smear		Date:	Results: Normal Abnormal
LEEP	[ ] Yes [ ] No	Date:	Results:
HPV	[ ] Yes [ ] No	Date:	

Obstetrics

Total number of pregnancies (including current): _____
Full term births _____
Preterm births (< 37 weeks) _____
Abortions _____
Miscarriages _____
Number of living children _____

Preg #	Delivery Date	# weeks at delivery	Gender	Birth Weight	Delivery Type	Complications	Location
1							
2							
3							
4							
5							
6							
7							

Personal Medical History:

Illness	Yes	Illness	Yes
Anemia (low iron)		Hypothyroid	
Anxiety/Depression		Hyperthyroid	
Asthma		Interstitial Cystitis	
Blood clot (DVT)		Irritable Bowel Syndrome	
Cancer, list type		Jaundice, Liver disease	
Crohn's, Ulcerative colitis		Migraines	
Diabetes type 1		Seizures	

Diabetes type 2		Sexually transmitted disease	
Heart disease		Stroke	
Hepatitis [] A [] B [] C		Tuberculosis	
High blood pressure		Uterine fibroids	
High cholesterol			

Other: _____

_____

Past Surgical History: [ ] None

Year	Surgery	Complications

Current Medications: [ ] None. If you need additional spaces, please attach an additional list.

Medication	Dosage, Frequency	Prescribing Provider

Allergies: (includes medication, food, environment) [ ] None [ ] Latex [ ] Iodine/Shellfish

Allergy	Reaction

Family Medical History: Please indicate age of onset, if known. [ ] None [ ] Adopted

Illness	Relationship
Blood clots/ DVT	
Cancer, indicate type	
Diabetes	
High blood pressure	
Stroke	
Stillbirth	
Birth Defects	
More than 3 miscarriages	
Genetic Disease, ex: cystic fibrosis, Tay Sachs, sickle cell	
Other	

Social History

Are you currently sexually active? [ ] Yes [ ] No

Have you ever had a sexually transmitted disease? [ ] Yes [ ] No If so, what kind? When? _____

Are you interested in screening for sexually transmitted diseases? [ ] Yes [ ] No

Do you currently drink alcohol? [ ] Yes [ ] No If so, how much and how often? _____

Do you currently use tobacco? [ ] Yes [ ] No If so, what kind and how often? _____

Do you currently use recreational drugs? [ ] Yes [ ] No If so, what kind and how often? _____

Life Style

Have you ever been a victim of domestic violence? [ ] Yes, currently [ ] Yes, in a prior relationship [ ] No

Do you feel safe at home? [ ] Yes [ ] No

Do you exercise? [ ] Yes [ ] No If so, what type and how often? _____

Do you have cats in your home? _____

Do you have close contact with children? _____

Have you ever had chicken pox? _____

Are you on a special diet? (i.e. gluten-free, diabetic, kosher) If so, what type? _____

Please provide any additional information that you think might be helpful. _____

_____

AUTHORIZATION AND RELEASE: I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as instructed by my physician.

_____ _____

Signature Date

Please email, mail, or fax your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, please arrive 30 minutes prior to your appointment time so we can review and process your information. Thank you for your attention and cooperation.