Hinsdale & Oak Brook Women's Clinic

PATIENT REGISTRATION FORM

DATE:_____

PATIENT INFORMATION

Last Name:	First Name:	MI:	Birth Sex: ☐ M ☐ F	Birth date: / /	Social Security Number:

Mailing Address:	City, State:	Zip Code:	County:

Home Phone: ( )	Cell Phone: ( )	Email Address:

Race (Circle One) White/ Black or African American/ American Indian or Alaska Native/ Asian/ Hawaiian or Pacific Islander/ Multi-racial/ Hispanic/Other:

Ethnicity: Hispanic or Latino origin? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other:

Interpreter Required? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Employer:	Work Phone:

GUARANTOR INFORMATION

Name of Responsible Party:	Birth date: / /	Relationship of Responsible Party to Patient: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Caregiver ☐ Other:

Address (if different than patient):	City, State:	Zip Code:

Home Phone: ( )	Cell Phone: ( )	Is this person a patient here? ☐ Yes ☐ No

EMERGENCY CONTACT

Name of local friend or relative:	Relationship to Patient:	Home Phone: ( )	Cell Phone: ( )

INSURANCE

(Please provide complete insurance information regardless of type of service utilizing. Provide all cards to the front desk.)

Primary *Medical* Insurance: ☐ Uninsured ☐ Medicare ☐ Medicaid ☐ Private/Commercial:

Subscriber Name: **Date of Birth:** / / **Policy/ID Number:**

Secondary *Medical* Insurance: ☐ Uninsured ☐ Medicare ☐ Medicaid ☐ Private/Commercial:

Subscriber Name: **Date of Birth:** / / **Policy/ID Number:**

Patient Pharmacy Information

Patient Drug Allergies:

Local Pharmacy: Name:_____ **Phone number:**_____

Fax Number:_____

Mail In Pharmacy: Name:_____ **Phone number:**_____

Primary Care Physician:_____ Phone Number:_____

Referring Physician:_____ Phone Number:_____

How did you hear about us?

_____

_____

_____

By signing below I agree that the above information is accurate and true to the best of my knowledge:

Patient/Guardian Signature:	Date:

Hinsdale & Oak Brook Women's Clinic
6803 Kingery Hwy Willowbrook, IL 60527
Phone: 630-323-0430 Fax: 630-323-5220

Hinsdale & Oak Brook Women's Clinic

Patient Medical History Information:

Name:_____ Date:_____ Age:_____ Date of Birth:_____

Reason for Visit Today:_____

_____

Any Previous History of this complaint?_____

_____

Medications: (Please list ALL current medications, vitamins & herbal supplements or bring a list of current medications)

Medication	Dose & Frequency	Medication	Dose & Frequency

Medication Allergies: **(**Please list **ALL** allergies; include allergies to latex & iodine/betadine)

☐ No Known Drug Allergies

Drug Name	Reaction

Personal Medical History: Please indicate current/prior medical problems related to you.

☐ No Significant Medical Problems

___High Blood Pressure
___Overactive Thyroid
___Underactive Thyroid
___Diabetes
___History of Stroke: Date_____
___History of Heart Attack: Date_____
___Migraine Headaches
___Other Headaches
___High Cholesterol
___Kidney Disease
___Cancer History: Type_____
___Asthma
___Seizure Disorder
___Liver Disease
___Hepatitis
___COPD

___Depression
___Anxiety
___Hx of Blood Clots (DVT)
___Neurologic Disorders
___Peripheral Vascular Disease
___Glaucoma
___Osteoporosis
___Fibromyalgia

GYN History

___Abnormal Pap Smears
___Vaginal Yeast Infections
___History Of Sexually Transmitted Infections
___Abnormal Mammograms
___Infertility

GYN History (Cont'd)

___Bartholin gland/cyst
___Abnormal Uterine Bleeding
___Heavy Menses
___Painful Menses
___Uterine cancer
___Ovarian cysts
___Ovarian cancer
___Fibroids of the uterus
___Polycystic ovaries
___Leaking urine (urinary incontinence)

Other medical problems:

_____

_____

_____

_____

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Past Surgical History: (Please list **ALL** surgeries including procedures to the cervix)

Procedure/Surgery	Date	Procedure/Surgery	Date

Ob/Gyn History:

Age of first period: ___
First day of last period: _____
Days of flow: ___
Clots with cycle: Yes No
Amount of flow: Heavy Moderate Light
Bleeding between periods: Yes No
Contraceptive method: _____
If menopausal, age at time of menopause: _____

Pregnancy History: (If never pregnant, please skip this section.)

Total number of pregnancies (including this one) _____
Number of deliveries _____
Abortions _____
Number of premature deliveries _____
Ectopic pregnancies _____
Miscarriages _____

Name Children:	DOB	Birth Weight	Sex	Vaginal or C-Section

Family History:

Cardiac disorders _____
High blood pressure _____
High cholesterol _____
Bleeding disorders _____
Heart Disease _____
Diabetes_____
Breast cancer _____
Colon cancer _____
Ovarian cancer _____
Other:_____

Caffeine Intake:
None
1-2 drinks/day
3 or more drinks/day

Calcium Intake:
1000mg calcium daily
Less than 1000mg calcium daily

Exercise:
1-2 times/week
3 or more times week
None
Sporadic

Seatbelt use:
Not regular
Always

Social History:

Marital Status:
Married
Single
Divorced
Widowed

Alcohol Use:
Frequent
Never
Occasional

Smoker:
Current
Never
Prior

Drug use:
Current
Never
Prior

Domestic Violence:
Current
Never
Prior

Screening Tests:	Date	Results
Ovarian Cancer Screening		
Pap Smear		
Mammogram		
Bone Density		
Cholesterol		
Colonoscopy		

Patient Signature: _____ **Date:** _____

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