PATIENT REGISTRATION FORM

Last Name (Print)_____ (First) _____ (MI) _____ (Previous/Maiden)_____

DOB_____ Marital Status: _____Single _____Married _____Divorced _____Sep. _____Widow_____

Address _____City _____State_____ Zip_____

Home#_____Work#_____Ext_____Cell#_____ **Circle best way to reach you**

E-Mail _____Employer _____ Occupation_____

Race: ( )White ( )Black/African American ( )Hispanic ( )Other:_____

Ethnicity: ( )Hispanic or Latino ( )Not Hispanic or Latino ( )Decline Language: ( )English ( )Spanish ( )Other:_____

ARE YOU CURRENTLY PREGNANT: _____Yes _____No

I have been seen by Annapolis OB-GYN within the past 12 months ____Yes ____No
NOTE: If you checked "Yes", do NOT complete the rest of the form unless your information has changed. If you checked "No", please continue to complete the rest of the form below this box. YOU MUST SIGN AT THE BOTTOM.

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PRIMARY CARE DOCTOR(Other than at this practice) _____Phone_____

PHARMACY_____LOCATION_____Pharm Phone:_____

EMERGENCY CONTACT_____Relationship_____

Emergency Contact's Home #_____Work#_____Cell#_____

YOUR PARTNER'S INFORMATION **(SPOUSE /PARTNER/BABY'S OTHER PARENT) (Please circle one)**

Name (Last) _____ (First) _____(MI)_____ DOB_____ SS#_____

Address_____City_____State_____Zip_____

Home# _____Work# _____Cell#_____

PRIMARY INSURANCE: Insurance Co. _____ Phone# _____

Name of Insured_____Patient Relationship to Insured _____DOB_____

Insurance Address_____Employer_____

Subscriber ID#_____ Group ID# _____ Co-Pay Amount_____

SECONDARY INSURANCE: Insurance Co. _____Phone#_____

Name of Insured_____ Patient Relationship to Insured _____DOB_____

Insurance Address_____Employer_____

Subscriber ID#_____ Group ID# _____ Co-Pay Amount_____

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I declare I have listed all the medical/health insurance plans from which I may receive benefits. I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I also understand that I am responsible for contacting AAMG Annapolis Ob-Gyn, in a timely manner, with any future changes in the above information, especially those that may affect the processing of my insurance claims.

Patient Signature _____Date_____

Parent or Guardian_____Relationship_____Date_____

For office use only

FD_____ CL_____

FAX TO: 443-837-2791 or E-MAIL TO: AOGpreregistration@aahs.org

updated 03/11/2020

HISTORY AND PHYSICAL RECORD

Print Name:_____**Date:**_____**DOB:**_____

Marital Status: (circle one) S Sep M D W Previously divorced?____ Previously widowed?___ Where were you born:_____

Place of Employment: _____ **Occupation:**_____

YOUR MEDICAL HISTORY: (Check off if you have had this illness, and write what type if applicable)

Disease	√	Type	Disease	√	Type	Disease	√	Type
Asthma			Kidney Dis/Infections			Epilepsy/Seizures		
Pulmonary Disease			High Blood Pressure			Hepatitis /Liver Disease		
Diabetes			Gastrointestinal Prob.			STD/HPV (list kind)		
Cancer			Depression/Anxiety			Herpes (list kind)		
Heart Disease			Chronic Bladder Infec.			Thyroid Disorder		
Hyperlipidemia			Osteoporosis			Blood Clotting Disorder		
Migraines			Addiction			Other:		

YOUR PAST SURGICAL/INJURY HISTORY: (List a D&C for a miscarriage in the OBSTETRICAL HISTORY below.)

Disease/Diagnosis/Injury	Procedure or Surgery Type	Date	Physician/Surgeon	Hospital

GYN HISTORY:

Menstrual Cycle:	Response	Menopause/Gyn:	Response
Age when period started?		Are you having peri-menopausal symptoms?	
Last menstrual period?		What are your symptoms?	
Periods are how many days apart?		Are you post-menopausal?	
How long does your period last?		Your age at menopause?	
Pain with menstrual period?		Type: Natural, Surgical, Premature, Chemo, Other?	
Do you bleed in between periods?		Pain with intercourse?	
Is your flow heavy, moderate or light?		Vaginal Dryness?	
Do you have pain between periods?		Bleeding with intercourse?	
Do you have a vaginal discharge?		Vaginal itching or odor?	
Is this normal for you?		Are you sexually active?	
Color and consistency of discharge?		Sexual orientation?	
		State method of contraception:	

RECENT SCREENINGS:

Screening	Date	Result	Screening	Date	Result	Screening	Date	Result
Bone Density			Colonoscopy			Pap		
Chest X-Ray			Cholesterol			Mammogram		

SOCIAL HISTORY:

SMOKING:	Response	CAFFEINE	Response	DRUGS:	Response
Do you smoke?		Do you drink caffeine?		Do you use drugs?	
How much do you smoke?		Amount/frequency?		Recovering from addiction	
Did you quit smoking?		Type of caffeine?		What type of addiction?	
How many years did you smoke?		**EXERCISE/SAFETY**			
		Do you exercise?		**MISC:**	
ALCOHOL		Exercise frequency?		Have you traveled outside of the US in the past year?	
Do you drink alcohol?		Wear seat belts?			
Amount/frequency?		Have a Living Will?		Where did you visit?	
Recovering from addiction?		Do you feel safe at home?			

OBSTETRICAL HISTORY: **Patient's Name:_____**

Date of Delivery	Weeks of gest.	Type of Delivery	Physician	Sex	Wt.	Abortion (Elective)	Miscarriage	List other problems/complications, outcome, and/or infertility history.

TOTALS: Enter totals below:

Total Pregnancies	# of Full Term	# of Premature	Elective Abortions	Miscarriages	Ectopic Pregnancy	Live Children

ALLERGIES:

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: (Include medications, birth control, vitamins & herbal supplements)

Name	Strength	Dosage	Reason	Name	Strength	Dosage	Reason

CHECK BELOW ANY DISEASE A BLOOD RELATIVE OF YOURS MAY HAVE, OR HAD: (Please write maternal or paternal side.)

Disease	Relative	Outcome	Disease	Relative	Age of Diagnosis
Addiction (list type)			Alzheimers		
Blood Disorder			Mental Illness (list type)		
Pulmonary			Epilepsy		
Depression			Cancer:		
Diabetes			Breast		
Osteoporosis			Colon		
Thyroid Disease			Ovarian		
High Blood Pressure			Uterine		
High Cholesterol			Skin		
Heart Disease (list type)			Other:		