ALBANY MED Health System

SARATOGA HOSPITAL
Medical Group

OB/GYN & Midwifery

PATIENT REGISTRATION

FIRST NAME (LEGAL)	PREFERRED FIRST NAME	MI	LAST NAME

MAILING ADDRESS	CITY	ZIP CODE

HOME PHONE	CELL PHONE	CELL PHONE CARRIER

WORK PHONE	EMAIL ADDRESS

DATE OF BIRTH	RELATIONSHIP STATUS (please circle one) NEVER MARRIED MARRIED DIVORCED SEPARATED WIDOWED DOMESTIC PARTNER OTHER _____

RACE (please circle one) WHITE BLACK AMERICAN INDIAN ASIAN OTHER _____	ETHNICITY (please circle one) HISPANIC ORIGIN NOT OF HISPANIC ORIGIN OTHER _____	LANGUAGE PREFERENCE (please circle one) ENGLISH OTHER _____	GENDER _____

PHARMACY	PRIMARY DOCTOR

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER

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 #

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 #

RELATIONSHIP TO INSURED	EFFECTIVE DATE OF INSURANCE PLAN	IF AUTO OR WORK RELATED, DATE OF INJURY

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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): _____

_____

MENSTRUAL HISTORY (answer all questions that apply to you) **SELF CARE**

Age at first menstrual period:	Have you had Gardasil vaccine? How many shots:
First day of last period:	Do you have regular checkups?
How many days between periods?	Date of last pelvic/pap exam:
How many days does period last?	Date of last mammogram:
Is your flow heavy, light, moderate?	Date of last bone density scan:
Any menstrual symptoms?	Date of last colonoscopy:

PROCEDURES

Have you ever had an abnormal pap smear? ☐ Yes ☐ No If yes, when? _____

Have you ever had any procedure to your cervix (i.e., colposcopy, LEEP)? ☐ Yes ☐ No

If yes, please specify:_____When? _____

BIRTH CONTROL

Current Birth Control Method: (Check which one applies)

☐ None ☐ Condoms ☐ Pills ☐ NuvaRing ☐ Nexplanon ☐ Depo Shot ☐ Essure ☐ Adiana

☐ IUD: _____Year placed _____ ☐ Tubal Ligation/Salpingectomy ☐ Hysterectomy ☐ Other: _____

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: ☐ Hot Flashes or night sweats	If yes, what?
☐ Sleeping difficulties ☐ Vaginal Dryness	If yes, for how long?
☐ Decreased Libido ☐ Other:	Are there any side effects?

PREGNANCY HISTORY **Are you currently pregnant? ☐ Yes ☐ No**

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 LIST ANY CHILDHOOD ILLNESSES

	Chickenpox		Measles		Rubella
	Chickenpox - Vaccine		Mumps		Scarlet Fever
	Other:				

PLEASE CHECK ALL MEDICAL PROBLEMS YOU HAVE OR HAVE HAD (Please check box to **LEFT** of illness or problem.)

	Abdominal Aortic Aneurysm		Drug Addiction		Lupus
	Acne		Eating Disorder		Mental Illness
	ADHD		Emphysema		Migraine with aura
	AIDS		Epilepsy		Migraine without aura
	Alcoholism		Esophagitis		Mitral Valve Prolapse (MVP)
	Seasonal Allergies		Fibrocystic Disease of Breast		Multiple Sclerosis (MS)
	Alzheimer's Disease		Fibromyalgia		Obesity
	Anemia		GERD		Osteoporosis
	Angina		Gallstones		Peptic Ulcer Disease
	Arteriosclerosis		Glaucoma		Palpitations
	Arthritis, Rheumatoid		Gonorrhea		Pancreatitis
	Arthritis, Osteo		Gout		Parkinson's Disease
	Asthma		Hard of Hearing		Peripheral Vascular Disease
	Atrial Fibrillation		Heart Attack (MI)		Phlebitis
	Bipolar Disorder		Heart Disease		Pneumonia
	Blood Transfusions		Heart Failure		Poliomyelitis
	Cancer* (List below.)		Heart Murmur		Psoriasis
	Carotid Artery Stenosis		Hemophilia		Pulmonary Embolism
	Cataracts		Hepatitis A		Rheumatic Fever
	Cerebrovascular Accident (CVA)		Hepatitis B		Scoliosis
	Cirrhosis		Hepatitis C		Seizure Disorder
	CNS Tumors		Herpes		Sickle Cell Anemia
	Colitis		Hiatal Hernia		Stroke
	Colon Polyps		HIV		Syphilis
	Congestive Heart Failure		Hodgkin's Disease		Transient Ischemic Attack (TIA)
	COPD		Hypercholesterolemia		Thyroid Disease
	Coronary Artery Disease		Hypertension		Hypothyroidism
	Crohn’s Disease		Incontinence		Hyperthyroidism
	Depression		Infertility		Grave’s Disease
	Dermatitis		Kidney Disease		Tuberculosis
	Diabetes- Insulin Dependent		Kidney Stones		Tumors
	Diabetes- Non-Insulin Dependent		Leukemia		Ulcers
	Diverticulitis		Liver Disease		Venous Insufficiency
	Diverticulosis		Lung Disease		Vertigo

***PLEASE LIST ANY CANCER HISTORY**

DATE	TYPE OF CANCER	THERAPY

ASSISTIVE DEVICES (List any assistive devices you wear or use, i.e. hearing aids, contact lenses, glasses, walkers.)

Patient Name: _____

SURGERIES AND PROCEDURES

DATE	TYPE OF SURGERY	SURGEON	HOSPITAL	COMPLICATIONS

HOSPITALIZATIONS (Please list all with dates.)

DATE	TYPE OF HOSPITALIZATION	PHYSICIAN	HOSPITAL	COMPLICATIONS

FOR GENETIC SCREENING PURPOSES, are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

CANCER TYPE	RELATIONSHIP	AGE AT DIAGNOSIS	**LIVING** (Yes /No) If no, age deceased
☐ **Breast cancer**			
☐ **Ovarian cancer**			
☐ **Endometrial cancer**			
☐ **Colon cancer**			
☐ **Pancreatic cancer**			

(Please list all family illnesses.)

RELATIVE	ILLNESSES & AGE AT DIAGNOSIS	**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)		

Patient Name: _____

SOCIAL/PERSONAL HISTORY

Highest level of education attained: _____ Marital Status: _____

Occupation: _____ Are you currently working? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No If no, please explain: _____

_____

_____

_____

Has anyone ever hurt you in any way? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

_____

Do you smoke? (Cigarettes or E-Cigarettes)	☐ 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 drink caffeine?	☐ Yes ☐ No	If yes, type and # cups per day:
Do you use Marijuana?	☐ Yes ☐ No	If yes, how often:
Do you use drugs?	☐ Yes ☐ No	If yes, type and how often:
Do you exercise?	☐ Yes ☐ No	If yes, type and how often:

Are you currently sexually active?	☐ Yes ☐ No	Is intercourse painful? ☐ Yes ☐ No
Total # of sexual partners in lifetime:	Is your sexual partner ☐ Male ☐ Female ☐ Other: _____	
Do you have any history of sexually transmitted diseases (STDs)?	☐ Yes ☐ No If yes, describe:	
What is your gender identity?	☐ Female ☐ Male ☐ Other: _____	
Sexual Orientation:	☐ Straight/Heterosexual ☐ Gay/Lesbian/Homosexual ☐ Bisexual ☐ Other (please specify): _____	

Are there any issues you would like to discuss today?

_____

_____

_____

Thank you for trusting us with your care