Divekar & Associates – Gynecology, Aesthetics & Wellness Center

Patient Registration Form Date:

Patient Information

Name:			Birthdate:		
SSN:	Age	Sex: M F	Marital Status: M S W D Other		
Address:		City:	State:	Zip:	
Home Phone:	Work Phone:		Cell:		
Employer:		Occupation:			
Emergency Contact:		Relationship:	Phone: :		
Nearest Relative:		Relationship:	Phone: :		
Primary Care Physician:		Patient Email:			

Primary Insurance (Please present card for verification)

Insurance Name:		Copay (PCP):	Copay (Specialty):	
Address:		City:	State:	Zip:
Subscriber Name:		Sex: M F	Birthdate:	
Subscriber Address:			Phone:	
Insurance Id:	Group:		Effective Date:	
SSN:	Relation to patient:	Employer:		
Employer phone:		Occupation:		

Person Responsible for bill (If other than self or legal guardian if under age 18)

Name:			Birthdate:		
SSN:	Age:	Sex: M F	Marital Status: M S W D Other		
Address:		City:	State:	Zip:	
Home Phone:	Work Phone:		Cell:		
Employer:		Occupation:			
Relationship to Patient:					

Divekar & Associates – Gynecology, Aesthetics & Wellness Center

Patient Name: Date of Birth

Gynecology History

Reason of visit: ☐Annual ☐Problem

Menstrual status

Last Period: .	Having Period ○ Yes ○ No	If No, Reason

Pregnancy

Date	Week gestation	Weight	Labor length	Sex	Type of delivery	Complications (if any)

Diet & Exercise

Diet information/concerns ☐Yes ☐No	Exercise (Specify type/amount) ☐Yes ☐No

Sexuality

Sexually Active ☐Yes ☐No	Partner ☐Male ☐Female	Birth Control ☐Yes ☐No Type

Past Medical History:

Past Surgical History:

Family History:

Mother:	Maternal grandparent:
Father:	Paternal grandparent:
Brother:	Other: FH ☐Breast ☐Ovarian ☐Uterine ☐Colon cancer
Sister:	FH ☐DVT ☐PE

Smoking:	Alcohol:	Drug use:
Allergies:		

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Patient Name: Date of Birth

Medications:

Gynecological History:

Age Of First Period:	
Period Frequency:	
How long do your period last:	
Painful Menstrual Cramps:	☐Yes/Mild ☐Yes/Moderate ☐Yes/Severe ☐No
Heavy Menstrual Flow: ☐Yes ☐No	Irregular Flow: ☐Yes ☐No
Does your menstrual flow affect the quality of your life? ☐Yes ☐No	
Any new partners since last exam? ☐Yes ☐No	Do you want STD testing? ☐Yes ☐No
STD History ☐No History ☐Gonorrhea ☐Chlamydia ☐Herpes ☐HPV ☐Genital Warts ☐HIV ☐Hepatitis	

Urinary Menopause Sexuality:

Mood changes	☐Yes ☐No	Urine leak with cough/sneeze:	
Vaginal discharge	☐Yes ☐No	Urine leak without cough/sneeze:	
Hot flushes	☐Yes ☐No	Painful urination:	
Dry skin	☐Yes ☐No	Night time urination:	
Decreased sex drive	☐Yes ☐No	Frequent urination:	
Decreased orgasm/Vaginal dryness	☐Yes ☐No	Night sweats	
Date of last PAP Smear		HPV Done?	☐Yes ☐No
Date of last Mammogram:		Have you ever had abnormal Mammogram?	☐Yes ☐No
Date of last Colonoscopy:		Date of last bone density scan?	
In a lifesaving situation would you accept a blood transfusion?		☐Yes ☐No ☐Maybe	

To be filled in office:

Height		Weight		BP	

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Patient Name: Date of Birth

Review of Systems: (Check all that apply)

CONSTITUTIONAL	EYES	GASTROTESTINAL	ENDO/HEME
☒Fever	☐Blindness	☐Heartburn	☐Cold intolerance
☐Chills	☐Blurred vision	☐Dysphagia (painful swallowing)	☐Heat intolerance
☐Weight gain	☐Double vision	☐Nausea	☐Polydipsia (Excessive thirst)
☐Weight loss	CARDIOVASCULAR	☐Abdominal pain	☐Polyphagia (Excessive desire to eat)
☐Malaise/Fatigue (Tired)	☐Chest pain	☐Diarrhea	☐Easily bruises/Bleeds
☐Night Sweats	☐Shortness of breath on exertion	☐Constipation	NEUROLOGICAL
☐Weakness	☐Palpitations	☐Blood in stool	☐Seizures
☐Decreased appetite	☐Orthopnea (Shortness of breath when laying down)	GENITOURINARY	☐Dizziness
SKIN	☐PND (Shortness of breath/ Coughing at night)	☐Incontinence	☐Lightheadedness
☐Rash	☐Claudication (Painful legs with walking)	☐Dysuria (Painful urination)	☐Speech change
☐Itching	☐Leg swelling	☐Urgency/Frequency	☐Focal weakness (Muscle weakness)
☐Skin Lesion	RESPIRATORY	☐Hematuria (Blood in urine)	☐Tremor
HEENT	☐Apnea (Brief stops in breathing)	☐Heavy Bleeding	☐Sensory change
☐Headaches	☐Shortness of breath	☐Pain with periods	☐Numbness/Tingling
☐Hearing loss	☐Wheezing	☐Pain with sex	PHSCHIATRIC
☐Tinnitus (Ringing in ears)	☐Snoring	☐Bleeding after menopause	☐Depression
☐Nosebleeds	☐Cough	☐Vaginal Discharge	☐Nervous/Anxious
☐Sore throat	☐Hemoptysis (Cough up blood)	MUSCULOSKELETAL	☐Insomnia (Trouble sleeping)
☐Sinus pain	☐Sputum production	☐Myalgia (Painful muscles)	☐Memory loss
BREAST	ALLERGY/IMMUNE	☐Back pain	
☐Breast Lump	☐Seasonal allergies	☐Joint pain	
☐Nipple Discharge	☐Latex allergy	☐Falls	
☐Painful breasts	☐Iodine allergy		

I am having none of these symptoms at this time ☐

Date: Signature: