

**PATIENT INFORMATION**

Gyn Patient Registration Information

Kimberly L. Evans, MD FACOG

Date \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PHARMACY \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMERGENCY CONTACT/RELATION \_\_\_\_\_

PHONE \_\_\_\_\_

**Meaningful Use**

Please answer circle the following questions REQUIRED by The Healthcare Financing Administration

**RACE**      American Indian/Native Alaskan      Asian      Black/African American  
                 Native Hawaiian/Pacific Islander      Hispanic      White      Other      Refuse to Report

**ETHNICITY**      Hispanic/Latino      Not Hispanic/Latino      Refuse to Report

LANGUAGE \_\_\_\_\_

- ARE YOU INTERESTED IN:
- Skin Care
  - Botox / Juvederm
  - hCG / Clean Start Weight Loss
  - Body Contouring
  - BioTe / Hormone Balance
  - Emsella
  - Incontinence
  - O-Shot / Vaginal Rejuvenation
  - PRP for Hair Loss

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Name _____		
Primary Care/Referring Physician _____		
Reason for Today's Visit? _____		
<b>CURRENT MEDICATIONS</b> (please feel free to continue on the back of this page if needed)		
Name of Medication	Strength	Dosage
<b>MEDICAL HISTORY</b> (If YES, please include dates)		
YES	NO	Diabetes
YES	NO	Hypertension
YES	NO	Cardiovascular/Lupus Disease
YES	NO	Autoimmune Disorder (i.e. Lupus, etc.)
YES	NO	Kidney Disease/UTI
YES	NO	Seizure Disorder/Neurological Issues
YES	NO	Psychiatric Issues
YES	NO	Hepatitis/Liver Disease
YES	NO	Varicose Veins/Vein Thrombosis
YES	NO	Thyroid Disease
YES	NO	History of Anemia/Blood Transfusion
YES	NO	Breast Problems
YES	NO	History of Cancer
YES	NO	Any problems with anesthesia
YES	NO	Other
<b>ALLERGIES TO MEDICINE?</b> YES NO (If YES, please list medicine and reaction)		
<b>SURGICAL HISTORY (Month/Year) Type of Surgery</b>		
<b>HOSPITALIZATIONS (Month/Year) Reason for Hospitalization</b>		
<b>FAMILY HISTORY OF ANY MEDICAL PROBLEMS? (If so, who is affected?)</b>		
<b>ANY HISTORY OF:</b>		
YES	NO	Smoking/Tobacco use? If YES, are you still smoking? (YES/NO)
YES	NO	Alcohol use? If YES, how many drinks per week?
YES	NO	Use of recreational/street drugs? If YES, what type? Are you still using?

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What is your occupation? \_\_\_\_\_

Marital Status?      Single    Married    Divorced    Widowed    Other

Name of partner \_\_\_\_\_

Who lives in your household? \_\_\_\_\_

\_\_\_\_\_

Any history of someone threatening to hurt you or make you feel uncomfortable? If YES, please explain

\_\_\_\_\_

\_\_\_\_\_

Do you need assistance today?    NO      YES

Date of last mammogram (Month/Year) \_\_\_\_\_

Date of last Bone Density Test (Month/Year) \_\_\_\_\_

Colonoscopy Screening (Month/Year) \_\_\_\_\_

**GYNECOLOGIC HISTORY**

How old were you when your periods started? \_\_\_\_\_

What was the first day of your menstrual period? \_\_\_\_\_

Still menstruating...

    Number of average days between the start of each period (i.e. 28 days) \_\_\_\_\_

    Number of days your period last? \_\_\_\_\_

    How would you describe your period?    Regular    Irregular

    Flow is      light      medium      heavy

    Bothersome      pain      cramps      Other

Not menstruating...

    Have you had a hysterectomy?    No    Yes, reason \_\_\_\_\_

    Do you still have your ovaries?    No    Yes

Are you sexually active? (circle all that apply)      Never      No      Yes      Yes, but not currently

    Heterosexual      Homosexual      Bisexual

Any problems with intercourse? \_\_\_\_\_

Method of birth control? \_\_\_\_\_

History of sexually transmitted diseases?    No    Yes, type \_\_\_\_\_

Date of last pap smear? \_\_\_\_\_

Have you ever had any abnormal pap smears?      No    Yes, when \_\_\_\_\_

Any breast problems? \_\_\_\_\_

**OBSTETRICAL HISTORY**

    Number of pregnancies   

    Living Children         

    Miscarriages             

    Abortions                

    Cesarean Deliveries

**Kimberly Evans, MD FACOG**

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**OFFICE POLICY**

**PHONE CALLS, MESSAGES, & PRESCRIPTION REFILLS** – It is our goal to answer all messages as soon as possible. However, please allow 1-2 business days for a return of your call unless it is an emergency. Please leave the reason for your call, as some messages can be handled quickly by the nurse. Please leave your best contact number at the time of when your prescription will run out, particularly for birth control methods. **Initial here** \_\_\_\_\_

**LABORATORY SERVICES** – These services are provided by Quest Diagnostics, Lab Corp and in-house lab primarily. It is the patient’s responsibility to assure that their insurance will cover labs drawn from this lab. Insurance companies often change their preferred laboratory therefore please check your coverage prior to each blood draw. These services are provided for the convenience of our patients and labs requested from our doctors only. **Initial here** \_\_\_\_\_

**TEST RESULTS** – It is our policy to inform patients of results in a timely fashion. Please inform the office of any change of your contact information. Remember, most tests take a week or more for results. Pap smear results are generally not available for at least two weeks. **Initial here** \_\_\_\_\_

**REFERRALS** – Some health plans require referrals for you to see a specialist. If you plan to see a specialist unrelated to your OB/GYN health you must obtain the referral from your primary care doctor. **Initial here** \_\_\_\_\_

**WELL WOMAN EXAM CONSENT** – An annual well woman exam is a once-a-year visit including your breast exam and pap smear. **An annual exam visit does not include discussion of new problems (discharge, etc.) or detailed review of chronic conditions, this may be subject to your deductible/copay.** **Initial here** \_\_\_\_\_

**LEAVING TELEPHONE MESSAGES**

\_\_\_\_\_ (Please Print Name) \_\_\_\_\_ D/O/B

\_\_\_\_\_ Authorize \_\_\_\_\_ Do Not Authorize

Dr. Kimberly Evans and her staff to leave a telephone message of any kind, pertaining to my medical care on my voice mail; that may include my name and the treating doctor’s name.

In case I cannot be reached, a message may be left with

\_\_\_\_\_ (Name) \_\_\_\_\_ Relationship

Best Contact Number \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Please check the box if you weigh over 350 lbs

