New Patient Registration

PATIENT INFORMATION

Kimberly L. Evans, MD FACOG

TODAY'S DATE ____________________ DATE OF BIRTH ________________________________

NAME ____ AGE __________

ADDRESS ____

STATE ____________ ZIP ______________

HOME ___________________________ CELL ___________________________ WORK ____________________

PHARMACY ____ PHONE ______________________

ADDRESS ____

May we contact you with promotions/events tyhrough your email? Yes No

EMAIL ADDRESS ____

EMERGENCY CONTACT ____

RELATIONSHIP ____

PHONE _______________________________________

Meaningful Use

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

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

ETHNICITY Hispanic/Latino Not Hispanic/Latino Refuse to Report

LANGUAGE ____

REASON FOR TODAY'S VISIT

- ☐ **Well Woman Exam/Pap**
- ☐ **BioTe / Hormone Balance**
- ☐ **Skin Care/ Microneedeling**
- ☐ **Botox / Juvederm**
- ☐ **Body Contouring/ Cellulite Reduction**
- ☐ **hCG / Clean Start Weight Loss**
- ☐ **PRP for Hair Loss**
- ☐ **Laser Hair Removal**
- ☐ **O-Shot / Vaginal Rejuvenation**
- ☐ **Emsella (incontinence)**
- ☐ **Other** ______________________________
  ____

How did you hear about us?___________________________________

ALLERGIES TO MEDICINE? YES NO (If YES, please list medicine and reaction)

____

____

CURRENT MEDICATIONS (please feel free to continue on the back of this page if needed)		
Name of Medication	Strength	Dosage

MEDICAL HISTORY (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

SURGICAL HISTORY (Month/Year) Type of Surgery

HOSPITALIZATIONS (Month/Year) Reason for Hospitalization

FAMILY HISTORY OF ANY MEDICAL PROBLEMS/ CANCER? (If so, who is affected?)

ANY HISTORY OF:

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?

____

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? YES NO

If YES, please explain ____

Do you need assistance today? NO YES

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

Sexual preference: Heterosexual Homosexual Bisexual

Have you completed your family? Yes No

Any problems with intercourse? ____

History of sexually transmitted diseases? No ________

Method of birth control? ____

FEMALE PATIENTS

Date of last mammogram (Month/Year) ____

Date of last Bone Density Test (Month/Year) ____

GYNECOLOGIC HISTORY

How old were you when your periods started? ____

What was the first day of your last 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

Date of last pap smear? ____

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

OBSTETRICAL HISTORY

Number of pregnancies		Miscarriages	
Living Children		Abortions	
Cesarean Deliveries			