Patient Registration Form

Date of Appointment:_____

Patient Information

Patient's First Name	Preferred Nickname	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Name _____ Gender _____ Age _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

☐ Well Woman Exam / Annual / Preventive Care

☐ Problem Visit
- Anything addressed that is not preventive may be subject to copay.

Do you have any concerns you would like to address?

_____

_____

_____

_____

Current Medications

What medication are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Penicillin ☐ Latex
☐ NSAIDS (ibuprofen, Naproxen, etc.) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism
☐ Seasonal Allergies
☐ Anemia
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Bleeding Disorder
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Depression
☐ Eating Disorder
☐ Epilepsy
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Migraines
☐ Osteoporosis
☐ Pneumonia
☐ Stroke
☐ Stomach Ulcer
☐ Substance Abuse
☐ Thyroid Disorder

Post Surgical History

☐ Cholecystectomy
☐ Hysterectomy
  ☐ Abdominal
  ☐ Vaginal
  ☐ Laparoscopic
☐ Appendectomy
☐ Breast Augmentation
☐ LEEP / Cold Knife Cone
☐ Bilateral Tubal Ligation
☐ C-Section
☐ Tonsillectomy
☐ D&C
☐ Bariatric Surgery
☐ Knee Surgery

Please list any other surgeries: _____

_____

_____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism
☐ Alzheimer's
☐ Anxiety
☐ Arthritis
☐ Bleeding Disorder
☐ Blood Disorder
☐ Cancer
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Genetic Disorder
☐ Glaucoma
☐ Heart Disease
☐ High Cholesterol
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disorder
☐ Lung Disease
☐ Psychiatric Disorders
☐ Osteoporosis
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disorder

Details: _____

_____

_____

_____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year: _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years: _____ # packs/day: _____

Do you smoke now?

☐ Yes ☐ No # packs/day: _____ year quit: _____

Do you use or have you ever used recreational drugs?

☐ Yes ☐ No types? _____ # times/week: _____

How much alcohol do you drink per week?

drinks/week: _____

How much caffeine do you drink per day?

drinks/day: _____

How often do you exercise?

times/week: _____

Name _____ Gender _____ Age _____ Date of Appointment: _____

OBGYN History

Have you ever had or do you currently have any of the following?

- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Breast Surgery
- ☐ Cervical Cancer
- ☐ Colposcopy
- ☐ Cryosurgery
- ☐ DES Exposure
- ☐ Extreme Menstrual Pain
- ☐ Fibroids
- ☐ Hot Flashes
- ☐ Endometriosis
- ☐ Infertility
- ☐ Irregular Periods/Bleeding
- ☐ Nipple Discharge
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer
- ☐ Painful Intercourse
- ☐ Pelvic inflammatory Disease
- ☐ Uterine Cancer
- ☐ Urinary Incontinence
- ☐ Yeast Infections - Frequent
- ☐ Polycystic Ovarian Syndrome

Sexually transmitted Infection History - Please check any current or prior infections

☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ DHPV

☐ Trichomoniasis ☐ Genital Warts ☐ Syphilis ☐ Other: _____

Pregnancy History

Please describe any pregnancies you have had.

_____

# of Pregnancies #Births # of Miscarriages # of Abortions

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

_____

_____

_____

_____

Are you currently pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No

Are you doing anything to prevent pregnancy?

☐ Yes ☐ No

If so what method?

☐ Condoms ☐ Withdrawal ☐ Pill ☐ Patch ☐ Nuvaring

☐ Nexplanon ☐ IUD ☐ Vasectomy

Do you need birth control or contraceptive advice?

☐ Yes ☐ No

Menstrual History

When was the first day of your last period? _____/_____/_____

How often does your period occur? (from first day to next)

every _____ days

☐ I am in Menopause: Year of last period_____

How many days does your period last? _____

How heavy are your periods? ☐ Light ☐ Normal ☐ Heavy

What age were you when you had your first period? _____

Health Exams

Please check and date all immunizations you have had.

- ☐ COVID-19 _____
- ☐ **Flu** _____
- ☐ Shingles _____
- ☐ Chicken Pox _____
- ☐ Tetanus _____
- ☐ Pneumonia _____

Please check and date tests you have had

☐ Blood Sugar-Fasting	_____	☐ Normal	☐ Abnormal
☐ Cholesterol Test	_____	☐ Normal	☐ Abnormal
☐ Colonoscopy	_____	☐ Normal	☐ Abnormal
☐ CT/CAT Scan	_____	☐ Normal	☐ Abnormal
☐ Dexascan (Bone Density)	_____	☐ Normal	☐ Abnormal
☐ EKG	_____	☐ Normal	☐ Abnormal
☐ Echocardiogram	_____	☐ Normal	☐ Abnormal
☐ Mammogram	_____	☐ Normal	☐ Abnormal
☐ MRI	_____	☐ Normal	☐ Abnormal
☐ Pap Smear	_____	☐ Normal	☐ Abnormal
☐ Cardiac Stress Test	_____	☐ Normal	☐ Abnormal
☐ Ultrasound	_____	☐ Normal	☐ Abnormal

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____
Reason for Today's Visit:_____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED
Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

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