Obstetric & Gynecology
PHYSICIANS OF FLINT, PC

Registration Form

PATIENT INFORMATION

NAME:	Last	First	M.I.

Date of Birth:	Have you ever been seen by a Doctor under a previous name? ☐ NO ☐ YES If YES, please give previous name:

Marital Status: M S W D	Email Address: *for office use only we NEVER share your email*

Social Security Number:	Primary Care Physician/Location:

Street Address:	City:	State:	Zip:

Phone:	Home	Cell	Work

Emergency Contact:	Name	Relation	Phone Number

If you are a dependent on your insurance policy please provide the name, date of birth and gender of the subscriber on the policy:

DEMOGRAPHICS

Gender:	Gender Identity:

Preferred Languages:	Primary	Secondary

Race: *Check all that apply*	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other Race: ___________________________ ☐ Unknown ☐ Decline to Specify
Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify

FOR OUR INFORMATION

What is your Preferred Pharmacy?	Name	Street/City

How did you hear about us?	

What is your preferred method of contact?	☐ Home Phone Call ☐ Cell Phone Call ☐ Mail ☐ E-Mail/Patient Portal Messaging

Reminder calls/texts/emails are sent automatically from our system 1 week, 2 days and 90 minutes prior to appointments that have not been confirmed. A staff member will also call you 1 business day prior to your appointment if it has not been confirmed.

Do you wish to opt out of automated calls/texts/emails? YES NO

Please read, sign and date the reverse side of this form.

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Health Questionnaire

PATIENT INFORMATION

NAME:	Last	First	M.I.
Date of Birth:	Age:	Primary Care Physician/Location:	
Gender:		Gender Identity:	

GYNECOLOGICAL HISTORY

Date of Last Menstrual Period (First Day):	Age Period Began:	Length of Periods:	Length of Cycles (time between periods):

Are you sexually active? ☐ Yes, currently ☐ Never ☐ In the past but not now	Number of Sexual Partners:	Lifetime	Currently	Gender of Sexual Partners: **Circle All That Apply**	Female Male Trans Other: _________

What do you currently use for birth control:	
What have you used in the past for birth control:	
Date of Last Pap Smear:	Results:
Date of Last Mammogram:	Results:
Date of Last Colonoscopy:	Results:

Check any/all items below that you currently experience and/or have a history of:

☐Abnormal Pap ☐ Infertility ☐ Hot Flashes ☐ Pelvic Pain
☐Abnormal Periods ☐ Endometriosis ☐ Vaginal Dryness ☐ Nipple Discharge
☐STI's ☐ Uterine Fibroids ☐ Mood Swings ☐ Ovarian Cysts
☐PID ☐ Breast Disease ☐ Sexual Problems ☐ Pelvic or Bladder Prolapse
☐Cervical cautery or freezing ☐ Female Cancer(s) ☐ Night Sweats ☐ Urinary Incontinence

PREGNANCY HISTORY

Are you currently pregnant?		Are you trying to get pregnant?	
Number of:	Pregnancies	Miscarriages	Abortions

Please list each delivery: **if you need more room, please use the space at the end of this packet**

Type of Delivery (Vaginal or C-Section)	*Year*	*Any Complications*

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MEDICAL HISTORY

Do you experience: **Check all that apply**

- ☐ Depression/Anxiety
- ☐ Blood in Urine
- ☐ Weight Loss
- ☐ Painful Urination
- ☐ Sleep Interruptions
- ☐ Heart Palpitations
- ☐ Bowel Changes
- ☐ Persistent Cough
- ☐ Temp. Intolerances
- ☐ Chest Pain
- ☐ Rectal Bleeding
- ☐ Sinus Problems
- ☐ Fainting Spells
- ☐ Swelling of Ankles
- ☐ Vomiting Blood
- ☐ Easy Bruising

Do you or have you ever had: **Check all that apply**

- ☐ Blood Transfusions
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Urinary/Bowel Problems
- ☐ Epilepsy/Seizures
- ☐ Heart Murmur
- ☐ Psychological Issues
- ☐ Pulmonary Embolism
- ☐ Lung Disease
- ☐ Migraines
- ☐ Thyroid Disease
- ☐ Arthritis/Back Problems
- ☐ Varicose Veins
- ☐ Kidney Disease
- ☐ Gallbladder Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Lupus
- ☐ Bleeding Problem
- ☐ Asthma
- ☐ Cancer
- ☐ Sickle Cell Trait
- ☐ Blood Clots
- ☐ Neuro. Disease (Aneurysm)

Allergies:

Allergen	Reaction

Medications:

Medication	Dose	Medication	Dose

Surgeries: **excluding deliveries listed on the previous page**

Procedure/Reason	Year	Facility

Please print your First and Last name and Date of Birth: ____

This ensures all pages are loaded to the correct patient

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Health Questionnaire

SOCIAL HISTORY

Who lives with you?				
Marital Status: M S W D		Family Problems? Y N		Spousal Problems? Y N
Occupation				
Occupational Concerns: **Circle** Stress Hazardous Substances Heavy Lifting Other_______________				
Please tell us about your use of the following:				
Tobacco	☐ Current ☐ Past	Type:	Amount:	How Long:
Alcohol	☐ Current ☐ Past	Type:	Amount:	How Long:
Drugs	☐ Current ☐ Past	Type:	Amount:	How Long:
In the last 12 months have you had issues with any of the follow? **Check all that apply**				
☐ Having enough food for yourself/family ☐ Homelessness/Housing ☐ Transportation ☐ Paying for Necessities (ie. Utilities, Diapers, Feminine Products, etc.) ☐ Physical/Emotional/Sexual Abuse				
If so, would you like a referral to resources? Y N What is your most urgent issue?				

FAMILY HISTORY

Condition	**Father**	**Mother**	**Mother's Parents**	**Father's Parents**	**Brothers/ Sisters**	**Aunts/ Uncles**	**Your Children**
Heart Disease							
High Blood Pressure							
Stroke							
Diabetes							
Thyroid Disease							
Menopause Problems							
Mental Illness							
Cancer							
Use this box to tell give details of the items you checked above, please make sure to list types of cancer and ages of diagnosis if known:							

Please print your First and Last name and Date of Birth: ____
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Health Questionnaire

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *Circle*				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have notices. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you experienced any of the above, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
For provider use			**TOTAL:**	

Please use this space for anything you could not fit in the spaces provided or for any other pertinent issues/ history you would like to discuss with your provider:

Patient Signature: ______________________________ **Date:** ______________

Reviewed By: ______________________________ **Date:** ______________

Please print your First and Last name and Date of Birth: ______________________________

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