GARY M. AGENA, M.D.
Obstetrics and Gynecology

NEW PATIENT REGISTRATION

Last Name	MI	First Name	Date of Birth
Social Security Number	Marital Status	Ethnicity/Language	
Address	City	State	Zip Code
Home Phone	Cell Phone	Email	
Work Phone	Occupation	Employer	
Emergency Contact Name	Phone	Relationship	
Pharmacy Name	Pharmacy Address	Pharmacy Phone	

Insurance Information

Insurance Company Name	Group Number	Insurance Holder's SSN
	ID Number	Insurance Holder's DOB
Insurance Holder's Name	Relationship to Patient Self__ Spouse__ Child__ Other__	Work Status Employed ____ Unemployed ____ Retired ____ Student ____
	Gender (circle one) Male Female	

Assignment of Insurance Benefits

I hereby authorize direct payment of medical/surgical benefits to Gary M. Agena, MD LLC for services rendered. I also understand that I am financially responsible for any payment and/or balance not covered by my insurance.

I hereby authorize any information about me to be released to my health insurance carrier and its agents, including any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Gary M. Agena, MD LLC to release any medical records that may be necessary for medical care or the processing of applications for financial benefits.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices which explains how my Protected Health Information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

Please Print: Patient Name (or Legal Guardian)	Relationship to Patient
Signature	Date

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OB/GYN HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. All information given will be kept strictly confidential.

Main reason for today's visit:_____

Other concerns:_____

PAST MEDICAL HISTORY

Please check all that apply

- ☐ Anemia or Blood Disorder
- ☐ Asthma
- ☐ Birth Defects
- ☐ Breast Cancer
- ☐ Cancer (Other)
- ☐ Convulsions
- ☐ Thyroid problems
- ☐ Depression
- ☐ Diabetes
- ☐ Ear problems
- ☐ Eye problems
- ☐ GI Problems
- ☐ HIV
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney or bladder problems
- ☐ Lung Disorder
- ☐ Nose or throat problems
- ☐ Varicosities
- ☐ Ovarian Cancer
- ☐ Other

PAST SURGICAL HISTORY

Surgery	Reason	Year	Hospital
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HISTORY

Please specify mother, father, sibling, maternal/paternal grandmother/father, or other:

- ☐ Cancer (please specify type) _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Stroke _____
- ☐ Other _____

SOCIAL HISTORY

Occupation	**Exercise** ☐ Less than 3 times/week ☐ None ☐ More than 3 times/ week	**Caffeine** Yes / No Drinks per day ___	**Education** Highest Completed ☐ Some HS ☐ High School ☐ 2 Year College ☐ 4 Year College ☐ Post Graduate
Tobacco Yes / No ☐ Cigarettes __ / day ☐ Other __/ day	**Alcohol** Yes / No If yes, how often? ☐ <3/week ☐ >3/week	**Drugs** Yes / No If yes, list type:	

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GYNECOLOGIC HISTORY

Last Pap Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal
Age at first menstrual period: _____
Menopausal: ☐Yes ☐No
Currently sexually active: ☐Yes ☐No
Birth Control Method (if applicable): _____
Date of last menstrual period: _____
Average bleeding duration: _____days

☐ Bleeding between periods
☐ Heavy periods
☐ Painful periods
☐ Hot flashes
☐ Night sweats
☐ Leaking urine
☐ Vaginal itch/ burn/ discharge
☐ Painful intercourse

Bleeding amount: ☐Light ☐Average ☐Moderate ☐Heavy ☐Extremely Heavy
Average cycle length: ☐22-24 days ☐24-26 days ☐27-29 days ☐28-30 days ☐Other ____

OBSTETRIC HISTORY

Number of Pregnancies (Including current, if pregnant): _____
Births: _____
Miscarriages: _____
Abortions: _____

PREVIOUS DELIVERIES

Date	Gender of Baby	Gestational Age	Birth Weight	Delivery Method	Anesthesia	Hospital	Complications
__/__/____	☐Male ☐Female	___weeks	__lbs__oz	☐Vaginal ☐C-Section ☐VBAC	☐Epidural ☐Spinal ☐General ☐None	☐St. Tammany ☐Lakeview ☐North Oaks ☐_____	☐Pre-Eclampsia ☐Gestational Hypertension ☐Gestational Diabetes ☐Pre-Term Labor ☐Fetal Distress ☐Other_____
__/__/____	☐Male ☐Female	___weeks	__lbs__oz	☐Vaginal ☐C-Section ☐VBAC	☐Epidural ☐Spinal ☐General ☐None	☐St. Tammany ☐Lakeview ☐North Oaks ☐_____	☐Pre-Eclampsia ☐ Gestational Hypertension ☐Gestational Diabetes ☐Pre-Term Labor ☐Fetal Distress ☐Other_____

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__/__/____	☐Male ☐Female	___weeks	__lbs__oz	☐Vaginal ☐C-Section ☐VBAC	☐Epidural ☐Spinal ☐General ☐None	☐St. Tammany ☐Lakeview ☐North Oaks ☐_______	☐Pre-Eclampsia ☐ Gestational Hypertension ☐Gestational Diabetes ☐Pre-Term Labor ☐Fetal Distress ☐Other__________
__/__/____	☐Male ☐Female	___weeks	__lbs__oz	☐Vaginal ☐C-Section ☐VBAC	☐Epidural ☐Spinal ☐General ☐None	☐St. Tammany ☐Lakeview ☐North Oaks ☐_______	☐Pre-Eclampsia ☐ Gestational Hypertension ☐Gestational Diabetes ☐Pre-Term Labor ☐Fetal Distress ☐Other__________
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MEDICATIONS

Please list all medications you are taking, including both prescription and non-prescription.

Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		

List others here:

_____

_____

ALLERGIES

List anything you are allergic to and how each affects you (include medications, foods, etc.)

Drug / Object	Reaction
1.	
2.	
3.	
4.	
5.	

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REVIEW OF SYSTEMS

Please mark all that apply:

Allergic / Immunologic
- ☐ Sinus pressure
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny nose

Cardiovascular
- ☐ Arm pain on exertion
- ☐ Chest pain on exertion
- ☐ Irregular heart beats
- ☐ Known heart murmur
- ☐ Short of breath when lying down
- ☐ Short of breath when walking

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss

Ear/ Nose/ Mouth/ Throat
- ☐ Bleeding gums
- ☐ Difficulty hearing
- ☐ Dizziness
- ☐ Dry mouth
- ☐ Ear pain
- ☐ Frequent nosebleeds
- ☐ Mouth breathing
- ☐ Nose/ sinus problems

Endocrine
- ☐ Fatigue
- ☐ Heat/cold intolerance
- ☐ Increased thirst
- ☐ Increased hunger

Eyes
- ☐ Dry eyes
- ☐ Irritation
- ☐ Vision changes

Gastrointestinal
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/ Vomiting
- ☐ Change in appetite
- ☐ Blood in stool
- ☐ Hemorrhoids

Genitourinary
- ☐ Heavy periods
- ☐ Absent periods
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ Vaginal discharge
- ☐ Vaginal irritation
- ☐ Pain with intercourse
- ☐ Urinary leakage
- ☐ Painful urination
- ☐ Urinary frequency
- ☐ Urgency

Hematologic/ Lymphatic
- ☐ Easy bruising
- ☐ Swollen glands

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Muscle weakness

Neurological
- ☐ Weakness
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory loss
- ☐ Migraines
- ☐ Seizures

Psychiatric
- ☐ Alcohol overuse
- ☐ Anxiety/ Stress
- ☐ Depression
- ☐ Sleep problems
- ☐ Feel unsafe in relationship

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Wheezing

Skin
- ☐ Eczema
- ☐ Rash
- ☐ Lesion

Please add any additional information you would like your doctor to know below:

_____
_____
_____
_____
_____

_____ Signature

_____ Date

Print name:_____

Relationship to Patient:
☐ Self ☐ Parent ☐ Guardian ☐ Caregiver