Adventist Health
Feather River Hospital
Feather River Women's Health Chico

MR# _____

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____
Birth Date _____Age_____Social Security No. _____
Language Preference _____ Female/Male (circle one) Race _____ Marital Status _____
Mailing Address _____Street Address _____
City/State _____Zip Code _____ Home Phone _____Cell_____
Personal email address: _____
Employer _____Emp.Address_____Emp. Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Number _____
Group Number _____ Insured Name _____ Date of Birth_____
Secondary Insurance_____ Policy Number_____
Group Number _____ Insured Name_____ Date of Birth_____

PERSON RESPONSIBLE FOR BILL (IF NOT PATIENT)

Last Name _____ First Name _____ Middle _____
Mailing Address _____ Street Address _____
City/State _____ Zip Code _____ Phone number _____
Birth Date _____Female/Male(circle one) Social Security No. _____
Employer _____ Phone _____ Relationship to patient_____

SPOUSE/PARENT

Last Name _____ First Name _____ Middle _____
Mailing Address _____ Street Address _____
City/State _____ Zip Code _____ Home/Message Phone _____
Birth Date _____ Female/Male(circle one) Social Security No. _____
Employer_____Phone_____ Relationship to patient_____

IN CASE OF EMERGENCY. NOTIFY (NOT LIVING WITH YOU)

Last Name _____ First Name _____ Middle _____
Birth Date _____Female/Male(circle one) Relationship to patient_____
Mailing Address _____ City/State_____ Zip Code_____
Home Phone _____Cell/Message Phone_____

Adventist Health
Feather River Hospital

Feather River Women's Health

111 Raley Blvd. Suite 240
Chico, CA 95928 (530) 332-1040

GENERAL INFORMATION

Name (last, first):_____ Date of Birth: _____
Address: _____ City;_____ State: _____ Zip :_____
Home Phone:_____ Work Phone: _____ Cell Phone :_____
Marital Status: ☐ Single ☐ Married _____#yrs ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-Law
Primary Physician or Clinic : _____ Specialists that I see: _____

PRESENT SYMPTOMS

Main Reason For Visit:
☐ Annual Exam ☐ Menstrual Problems ☐ Hormonal Problems ☐ Vaginitis ☐ Birth Control
☐ Menopausal Problems ☐ Pelvic Pain ☐ Infertility ☐ Urinary Incontinence
☐ Referral from another physician ☐ I want a screening for STD
☐ Other: _____

GYNECOLOGIC HISTORY

Age at first period: _____ Last period: _____ When was the period before that? _____
How far apart are your cycles? _____ How many days do they last? _____

Are you currently sexually active?	☐ Yes	☐ No	Age at first intercourse: _____ # of sexual partners:_____
Symptoms associated with your Period:	☐ Yes	☐ No	
Current form of birth control	☐ Yes	☐ No	
Previous forms of birth control	☐ Yes	☐ No	
Abnormal Pap Smear	☐ Yes	☐ No	
Infertility	☐ Yes	☐ No	
Infections	☐ Yes	☐ No	
Do you use douches?	☐ Yes	☐ No	
Vaginal Discharge?	☐ Yes	☐ No	
Cramps	☐ Yes	☐ No	
Pelvic Pain	☐ Yes	☐ No	

MENOPAUSE SYMPTOMS

☐ Yes ☐ No Describe Symptoms : _____
_____

OBSTETRICAL HISTORY (Please list all pregnancies, including miscarriages and ectopic pregnancies)

Year	Mode of Delivery	Anesthesia	Gestational Age	Gender	Weight	Complications

MEDICAL/SURGICAL HISTORY

Please list all significant prior medical illnesses, hospitalizations and current medical problems for which you are under treatment.

MA Intake:	**Physician Review & Comments:**
Past Medical History: Date:	
Past Medical History: Date:	
Past Medical History: Date:	
Past Surgical History Date:	

Name:

MEDICATIONS

Please list all current medications – Prescription and non prescription, herbs, vitamins, etc.

Medication	Dosage	Frequency	Reason for medication, prescribing physician, pharmacy

ALLERGIES

Do you have allergies to any medication?	☐ Yes	☐ No	Please list:
Do you have any allergies to latex?	☐ Yes	☐ No	

SOCIAL HISTORY

Do you smoke cigarettes? ☐ Yes ☐ No How many cigarettes a day? _____

If yes, are you interested in stopping smoking? ☐ Yes ☐ No ☐ patches ☐ Wellbutrin ☐ gum ☐ classes

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____

FAMILY HISTORY (mark those that apply)

Alcoholism	☐Yes	☐No	
Arthritis	☐Yes	☐No	
Bleeds easily	☐Yes	☐No	
Cancer (type)	☐Yes	☐No	
Colon polyps	☐Yes	☐No	
Diabetes	☐Yes	☐No	
Glaucoma	☐Yes	☐No	
Heart Disease	☐Yes	☐No	
Hypertension	☐Yes	☐No	
Kidney/Gallbladder	☐Yes	☐No	
Mental illness/Depression	☐Yes	☐No	
Osteoporosis	☐Yes	☐No	
Phlebitis/pulmonary embolus	☐Yes	☐No	
Stroke	☐Yes	☐No	
Thyroid disease	☐Yes	☐No	
Tuberculosis	☐Yes	☐No	
Other inherited disease	☐Yes	☐No	
Details:			

REVIEW OF SYMPTOMS – Please mark any problems

General / Constitutional	☐Yes	☐No	
Eyes/Glasses	☐Yes	☐No	
Ears/Nose/Throat/Mouth	☐Yes	☐No	
Heart Disease/Hypertension	☐Yes	☐No	
Respiratory/Asthma	☐Yes	☐No	
Gastrointestinal	☐Yes	☐No	
Kidney/Gallbladder	☐Yes	☐No	
Bone Fracture	☐Yes	☐No	
Skin	☐Yes	☐No	
Neurological/Headaches	☐Yes	☐No	
Psychiatric/Depression	☐Yes	☐No	
Breast	☐Yes	☐No	
Thyroid	☐Yes	☐No	
Hematology/Lymphatic	☐Yes	☐No	
Allergic/Immunologic	☐Yes	☐No	
Partner Violence	☐Yes	☐No	

Signed:_____ **Date:**_____