Texas Tech Physicians
of LUBBOCK
OBSTETRICS & GYNECOLOGY

REGISTRATION FORM

Name____ Date of birth ____________________
Name you prefer to be called ____
Phone (home)__________________________________(work) ____________________________
Address ____
City____ Zip _______________________
Your Occupation ____
Insurance Company ____
Social Security #____________________________Driver's License # _____________________
Employer____
Marital Status__________________________________ Spouses Name _____________________
Spouse's Employer ____
Responsible party (if minor) ____
Emergency Contact ____
Address____ Phone ___________________________
How did you hear about us? [ ]Physician referral [ ]Newspaper ad [ ]Friend [ ]Family Member [ ]Other
Name of person who referred you ____

MEDICAL HISTORY

1. Reason for appointment ___________________________________ Age _________________
2. When was your last menstrual period? ____
3. How many periods do you have per year? ____
4. Length of menstrual cycle (number of days between periods) _________________________
5. Number of days of menstrual flow ____
6. Are you on hormone replacement medication? If yes, name ___________________________
7. Total number of pregnancies _______________ Number of living children _____________
   Miscarriages ___________ Abortions _____________ Premature births _______________
   Cesarean sections _____________
8. Do you smoke? [ ] Yes [ ] No How much? ____________________________________
9. Do you drink? [ ] Yes [ ] No How much? _____________________________________
10. Do you have any general medical problems? _____________________________________
11. When was your last tetanus shot? ____
12. What year was your last mammogram? ____
13. When was your last pap smear? ____
14. Do you do a self breast-exam every month? [ ] Yes [ ] No
15. List all current medications: ____
    ____
16. Drug allergies: ____