Lila L. Schmidt, MD
OB/GYN, Reproductive Endocrinology/Infertility
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PATIENT REGISTRATION FORM

Full Name (first, middle, last):	Date:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	DOB:

Contact Information	
Home Phone:	Cell Phone:
Home Street Address:	
City, State, Zip:	
Email Address 1:	Email Address 2:
Employer:	Work Phone:
Employer's Address:	

Emergency Contact Information				
Person to contact if we can't reach you?	☐ Spouse	☐ Parents	☐ Partner	☐ Other
Name of Contact:				
Primary Phone:	Secondary Phone:			
Closest relative not living with you:			Relationship:	
Name:				
Primary Phone:	Secondary Phone:			
Home Address:				

Primary Insurance Information	
Name of Carrier:	Phone:
Address:	
Group #:	ID or Policy #:
Name of Policy Holder:	Phone:

I hereby give authorization for payment for insurance benefits to be made directly to Lila L. Schmidt, M.D., and assistants for services rendered. In the event insurance payments are sent to either the patient or the insured, within 7 days, equivalent payment will be turned over to Dr, Schmidt. I understand that I am financially responsible for all charges, **including but not limited to insurance underpayments and non-covered services,** whether or not paid by insurance. Any fees incurred during the collection of my payment including, but not limited to, attorney fees, court fees or collection agency fees will be my full responsibility. I am also responsible for obtaining any and all insurance authorizations. I further agree that a photocopy of this agreement shall be as valid as the original. Cancellations with less than 24 hours notice or missed appointments are subject to a $35 fee.

Patient Signature: **Date:**

Patient Name:	DOB:

Date:	Age:
Relationship Status:	Spouse/Partner's Name:

Family History			
Has Anyone In Your Family Had:			If Yes, Who? At What Age?
Cancer (list specific type)	☐ No	☐ Yes	
Menopause (before age 35)	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
High Blood Pressure	☐ No	☐ Yes	
Bleeding Tendency	☐ No	☐ Yes	
Mental Illness	☐ No	☐ Yes	
Other	☐ No	☐ Yes	

Patient History			
Operations (What, when, where?):			
Previous serious illness and/or other hospitalizations?			
Drug allergies?	☐ No	☐ Yes	Specific drugs:
Transfusions?	☐ No	☐ Yes	When?
Do you require antibiotics prior to a dental procedure or cleaning?	☐ No	☐ Yes	

Gynecological and Obstetrical History			
First day of last period:		Was it normal? ☐ No ☐ Yes	
Age at onset of period:	Days of flow:		
What birth control are you currently using? ☐ None ☐ IUD ☐ Condoms ☐ Oral Contraceptive ☐ Other:			
Are your periods regular (26-33 days start to start)? ☐ Yes ☐ No Explain:			
Pain with periods?	☐ No	☐ Yes	Doctor's Comments:
Tension or headaches with periods?	☐ No	☐ Yes	
Bleeding between periods?	☐ No	☐ Yes	
Bleeding during or after sex?	☐ No	☐ Yes	
Any pain with sex?	☐ No	☐ Yes	
Any questions about sex for the doctor?	☐ No	☐ Yes	
Do you have an abnormal discharge?	☐ No	☐ Yes	
Have you ever had a venereal disease (i.e. HPV)?	☐ No	☐ Yes	
Have you ever had a pelvic infection?	☐ No	☐ Yes	
Have you passed the "change of life" (menopause)?	☐ No	☐ Yes	
If YES, any bleeding now?	☐ No	☐ Yes	
Any hot flashes now?	☐ No	☐ Yes	
Do you take hormones now?	☐ No	☐ Yes	
Do you do breast self exams?	☐ No	☐ Yes	
Have you noticed any lumps or discharge from your breasts/nipples?	☐ No	☐ Yes	
When your bladder is empty, do you lose urine when you cough or sneeze?	☐ No	☐ Yes	

Patient Name:	DOB:

Pregnancies Listed in Order (include miscarriages, abortions & deliveries)		
Delivery Date	Birth Weight of baby	Complications (C-section, cerclage, problems achieving pregnancy, etc.)

SKIN	Problem TODAY	Past Problem	Never	URINARY TRACT	Problem TODAY	Past Problem	Never
Bruise easily?	☐	☐	☐	Kidney or bladder infection?	☐	☐	☐
Prolonged bleeding from cuts?	☐	☐	☐	Pain, urgency or burning with urination?	☐	☐	☐
A sore throat that doesn't heal?	☐	☐	☐	Passed blood in urine?	☐	☐	☐
Blood clots (in legs)?	☐	☐	☐	Sugar in your urine?	☐	☐	☐

EYES	Problem TODAY	Past Problem	Never	ENDOCRINE	Problem TODAY	Past Problem	Never
Wear glasses?	☐	☐	☐	Unduly sensitive to heat or cold?	☐	☐	☐
Have blurred vision (with glasses)?	☐	☐	☐	Thyroid trouble?	☐	☐	☐
See double (with glasses)?	☐	☐	☐	Diagnosed with diabetes?	☐	☐	☐
See spots or halos around lights (with glasses)?	☐	☐	☐	Has your weight increased over 10 lbs in last year?	☐	☐	☐

EARS	Problem TODAY	Past Problem	Never	NEUROMUSCULAR	Problem TODAY	Past Problem	Never
Difficulty hearing?	☐	☐	☐	Convulsion/Seizures?	☐	☐	☐
Ringing in ears?	☐	☐	☐	Swollen, red or stiff joints?	☐	☐	☐
Frequent dizzy spells?	☐	☐	☐	Paralysis or deformity?	☐	☐	☐

NOSE, MOUTH, THROAT	Problem TODAY	Past Problem	Never	GASTROINTESTINAL	Problem TODAY	Past Problem	Never
Frequent nose bleeds?	☐	☐	☐	Frequent change in appetite?	☐	☐	☐
Wear dentures?	☐	☐	☐	Chronic constipation or diarrhea?	☐	☐	☐
Sore, sensitive, bleeding gums?	☐	☐	☐	Recent change in bowel habits	☐	☐	☐
Frequent sore throats?	☐	☐	☐	Bloody or tarry stools?	☐	☐	☐
Hay fever or allergies?	☐	☐	☐	Thirst you can't satisfy?	☐	☐	☐

Patient Name:	DOB:

CHEST	Problem TODAY	Past Problem	Never	CHEST	Problem TODAY	Past Problem	Never
High blood pressure?	☐	☐	☐	Cough up blood?	☐	☐	☐
Heart trouble or murmur?	☐	☐	☐	Ankle swelling?	☐	☐	☐
Severe shortness of breath?	☐	☐	☐	Heart often skips a beat or race?	☐	☐	☐
Chronic cough?	☐	☐	☐	Heart pain?	☐	☐	☐

Personal Information

Marital Status?	If married, how long?
○ Married ○ Single ○ Divorced	If divorced, how long?
○ Widowed ○ Life Partner	Is your marriage satisfactory?
○ Other:	Other: Partner's gender? ☐ male ☐ female
Unusually depressed? ☐ No ☐ Yes	Any particular problems?
Drink alcohol? ☐ No ☐ Yes	Number of Drinks per week?
Is it Red Wine? ☐ No ☐ Yes	
Smoke tobacco? ☐ Never ☐ Current User ☐ Past User	Number of packs per day? approx. date quit?
Are you currently taking any type of medication? ☐ No ☐ Yes	
If so, what? (i.e. Vitamins/birth control pills/herbs, etc.)	
Do you exercise regularly? ☐ No ☐ Yes	How often?
Approximately how many 8 ounce glasses of water do you drink per day?	

Additional Information

Include infertility tests, treatment(s), hysterosalpingogram (HSG), injections, Clomid, IUI, IVF, etc.

Last Annual:

Results:

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