Molly Katz, MD
71 E. Hollister St.
Cincinnati, Ohio 45219
Phone #: (513) 723-0909 Fax #: (513) 333-3024

PATIENT REGISTRATION

Date: ___/___/____

Name: _____ Date of birth: ___/___/____

Street Address: _____

City/State: _____ ZIP Code: _____

Social Security Number: _____-____-_____

Email Address: _____

Phone Numbers:

Home: _____-____-_____

Cell: _____-____-_____

Work: _____-____-_____

Contact Preference: Home Ph Mobile Ph Work Ph Mail Portal

Emergency/Alternate Contact: _____

Phone Number: _____ Relationship to Patient: _____

Marital Status (please circle):

Single Partnered Married Divorced Separated Widowed

Do you consider yourself to be (please circle): Hispanic/Latino **or** Non-Hispanic/Latino

Do you consider yourself to be:

_____ White
_____ Black or African American
_____ Asian
_____ American Indian or Native American
_____ Native Hawaiian or Pacific Islander

Primary Care Physician: _____ Phone #: _____

Specialty Physician: _____ Phone #: _____

Pharmacy Name: _____ Location: Phone #: _____

How did you hear about our practice? _____

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INSURANCE INFORMATION

Primary Insurance Company: _____

ID/Certification #: _____ Group #: _____

Subscriber/Guarantor: _____ D.O.B.: ____/____/_____

Relationship to Patient: _____

Secondary Insurance Company: _____

ID/Certification #: _____ Group #: _____

Subscriber/Guarantor: _____ D.O.B.: ____/____/_____

Relationship to Patient: _____

Patient Signature: _____ Date:____/____/_____

HEALTH HISTORY

If you have a list(s) of any of the following that can be provided, then you will not need to fill out those sections that correspond to the provided list(s).

SURGICAL HISTORY

Please list any surgeries you have had	Year

MEDICATION HISTORY

Medications currently taken on a regular basis (including any over-the-counter medications, vitamins, and herbal supplement):

Name of Medication	Taken for: (e.g. High BP)	Dosage (e.g. 10mg)	Amount / # of tablets daily (e.g. two tablets twice a day)

ALLERGIES

Including medication, latex, foods, etc.	Reaction is: (e.g.: “rash”, “hives”, “shortness of breath”, etc.)

VACCINATIONS

Influenza (flu)	Approximated date received:
Herpes Zoster (shingles)	Approximated date received:
Pneumococcal (pneumonia)	Approximated date received:
Gardasil (prevents high-risk genital warts)	Approximated date received:
Cervarix (prevents high-risk genital warts)	Approximated date received:
Tetanus	Approximated date received:
DTaP (diphtheria, tetanus, pertussis)	Approximated date received:

FAMILY MEDICAL HISTORY

We're particularly interested in the medical history of the following family members:

Mother=M	Maternal grandmother=MGM	Maternal Aunt=MA
Father=F	Maternal grandfather=MGF	Maternal Uncle=MU
Sister=S	Paternal grandmother=PGM	Paternal Aunt=PA
Brother=B	Paternal grandfather=PGF	Paternal Uncle=PU

Please use these abbreviations in the grid below. If your relative is deceased, please circle above and indicate the age at which they died.

Condition	**Relationship**
Breast Cancer	
Colon Cancer	
Ovarian, endometrial, or uterine cancer	
Other Cancer (please specify)	
Heart disease / heart attack	
High blood pressure	
High cholesterol	
Stroke	
Blood clot in leg or lung	
Blood clotting disorder or varicosities	
Diabetes	
Hip fracture or osteoporosis	
Thyroid problem	
Kidney disease	
Neurological problems	
Depression / psychiatric problems	
Alzheimer's / dementia	
Alcoholism	
Other:	

SOCIAL HISTORY

Are you working outside of your home?	□ Yes	□ No
What is your occupation?		
Are you caring for children/parents?	□ Yes	□ No
Do you exercise regularly?	□ Yes	□ No
Type and frequency?		
Alcohol intake per week?		
Smoking status: (please circle)	Never	Former Current
Do you have a history of abuse or current abuse (sexual, physical, emotional)?	□ Yes	□ No
ARE YOU SAFE?	□ Yes	□ No

PAST MEDICAL HISTORY

	Check One	Notes
Anemia or blood disorder	□ Yes □ No	
Arthritis	□ Yes □ No	
Birth defects or inherited disease	□ Yes □ No	
Cancer (if yes, please specify in the notes field)	□ Yes □ No	
Clotting disorder	□ Yes □ No	
History of DVT or PE	□ Yes □ No	
Convulsions / seizures / fainting	□ Yes □ No	
Depression	□ Yes □ No	
Diabetes	□ Yes □ No	
Ear problems	□ Yes □ No	
Eye problems	□ Yes □ No	
GI problems	□ Yes □ No	
Headaches / migraines	□ Yes □ No	
Heart condition	□ Yes □ No	
Hepatitis	□ Yes □ No	
High blood pressure	□ Yes □ No	
High cholesterol	□ Yes □ No	
Hyperthyroidism	□ Yes □ No	
Hypothyroidism	□ Yes □ No	
Kidney or bladder problems	□ Yes □ No	
Lung disorder or asthma	□ Yes □ No	
Nose or throat problems	□ Yes □ No	
Varicosities	□ Yes □ No	
Other significant conditions (please specify in notes)	□ Yes □ No	

GYNECOLOGIC HISTORY

Are you post-menopausal?	□ Yes □ No
If not, when did your last menstrual period being?	/ /
Do you have regular menses?	□ Yes □ No
Sexual orientation: (please circle) Heterosexual	Homosexual Bisexual
Are you sexually active?	□ Yes □ No
New sexual partner in the last year?	□ Yes □ No
If you're not post-menopausal, are you using anything to prevent pregnancy?	□ Yes □ No
Have you had a colonoscopy? If yes, what year?	□ Yes □ No
Have you ever had an ABNORMAL pap smear?	□ Yes □ No
Have you had a mammogram? If yes, what month/year of most recent and where was it done?	□ Yes □ No
Have you had a bone density test (dexascan)?	□ Yes □ No

If yes, what year of most recent and where was it done?	
Have you had any bone fractures?	□ Yes □ No
Has your mother or a sibling had a hip fracture?	□ Yes □ No
Did your mother take DES while pregnant with you?	□ Yes □ No
Do you have a history of treatment for infertility?	□ Yes □ No
Have you had any of the following gynecologic surgeries?	
Hysterectomy (Uterus removed)	□ Yes □ No
LEEP or conization of the cervix	□ Yes □ No
Oophorectomy (one or both ovaries removed)	□ Yes □ No
Tubal Ligation	□ Yes □ No

OBSTETRIC HISTORY

Total number of pregnancies	Full-Term	Pre-Term	Abortion	Ectopic	Multiple	Living

Patient Signature: _____ Date: ____/____/____