

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Fuoss, LaBuda, Santerini, McIntyre, Covatto, Silverman

Sewickley  
301 Ohio River Blvd, Suite 301  
(412)741-6530

Moon  
1009 Beaver Grade Rd., Suite 200  
(412)264-2450

# Premier Women's Health

## OBSTETRICAL REGISTRATION FORM

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Race \_\_\_\_\_ Marital Status \_\_\_\_\_ Years Married \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 Religion \_\_\_\_\_ Education \_\_\_\_\_ SS # \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Name of Father of Baby \_\_\_\_\_  
 His Home Phone \_\_\_\_\_ His Work Phone \_\_\_\_\_  
 Does he have any significant diseases, including congenital birth defects? \_\_\_\_\_ If so, please list:

### FAMILY HISTORY

The following history pertains to your side of the family only. If any of your family members have had any of the following, please list which family member (mother, father, etc., also maternal or paternal).

- |  |                          |
|--|--------------------------|
| 1. Tuberculosis _____                        | 6. Epilepsy _____        |
| 2. Hypertension _____                        | 7. Allergies _____       |
| 3. Heart Disease _____                       | 8. Multiple Births _____ |
| 4. Diabetes _____                            | 9. Birth Defects _____   |
| 5. Neurological-Psychological Problems _____ |                          |

### MENSTRUAL HISTORY

- Age of first menstrual period \_\_\_\_\_
- Menstrual flow occurs every \_\_\_\_\_ days
- Menstrual flow lasts \_\_\_\_\_ days
- Amount of flow (normal, heavy, etc.) \_\_\_\_\_
- Date of last menstrual period \_\_\_\_\_
- Was it a normal period? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Has your Primary Care Physician been advised of your pregnancy? \_\_\_\_\_

What kind of insurance do you have? \_\_\_\_\_

(Please give your insurance cards to the receptionist so copies can be placed in your medical record.  
If you don't have insurance, the Billing Office will set up a payment plan for you.)

In case of Emergency, please notify \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_