Riley Perry Lloyd, MD, FACOG

DATE:_____

HOW WOULD YOU LIKE TO BE ADDRESSED BY THE STAFF: _____

NAME: _____ _____/_____/_____
FIRST INITIAL LAST D.O.B.

STREET:_____ #_____

CITY:_____ STATE:_____ ZIP CODE:_____

(_____)_____ (_____)_____
PATIENT TELEPHONE W/ AREA CODE WORK TELEPHONE W/ AREA CODE

EMAIL: _____ @ _____

_____ _____
OCCUPATION EMPLOYER

PLEASE CIRCLE: SINGLE LIFE PARTNER MARRIED SEPARATED DIVORCED WIDOW

REFERRED BY: _____

_____ _____
EMERGENCY CONTACT NAME RELATIONSHIP TO PATIENT

(_____)_____
AREA CODE & TELEPHONE OF EMERGENCY CONTACT

4905 Old Orchard Center, Suite #330
Skokie, IL 60077

Phone: 847.763.7100 | Fax: 847.763.7102

Be Well Family Care
11495 N. Pennsylvania Street, Suite #270
Carmel, IN 46032

Patient Consent to Leave a Detailed Messages/Information

Dear Patient:

Dr. Lloyd requires our staff to obtain prior authorization to leave detailed voicemail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may only leave their name and a phone number in a message asking you to call them back.

By completing this consent below, you hereby authorize the staff to call and leave their name, the doctor's name, and any additional information *including test results* on a voicemail/answering machine and/or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I _____ (*print your name*) give my consent to Dr. Lloyd and/or his staff to leave voicemail/messages regarding appointments, treatments, test results, or any other necessary information at the numbers listed below.

Cell phone voicemail (_____) _____ - _____

Home voicemail (_____) _____ - _____

_____ _____/_____/_____

Patient Signature Date

I _____ (*print your name)* **DO NOT GIVE MY CONSENT TO ANY MESSAGES BEING LEFT ON A VOICEMAIL OR ANSWERING MACHINE OTHER THAN THE CALLER'S NAME AND PHONE NUMBER.**

_____ _____/_____/_____

Patient Signature Date

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PATIENT REGISTRATION FORM: FEMALE

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Primary Care Physician Name: _____

Physician Phone Number: _____ **Date of last visit:** _____

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1. What is the reason for your visit today? If it is a problem, please describe the symptoms and be specific: _____

2. Date of last pap smear: _____ Results: _____

   If abnormal, list treatment: _____

3. **Date of last mammogram:** _____ Results: _____

   If abnormal, list treatment: _____

4. Do you have or have you ever had breast cancer? □ YES □ NO

   If yes, please describe treatment: _____

5. Date of last menstrual period: _____

6. Are your menstrual periods regular? □ YES □ NO

   If no, please explain_____

7. If you no longer have periods, please check the reason:

   □ Hysterectomy □ Ablation □ Menopause & Age of Menopause: _____

8. Have you had any abnormal bleeding in the past year? □ YES □ NO

   If yes, please describe: _____

9. Please list any medications you are currently taking and dosage amounts: _____

   _____

10. **Do you have any drug allergies?** □ YES □ NO

    If yes, please list drugs you are allergic to: _____

    _____

11. Do you have any thyroid problems? □ YES □ NO

    If yes, which type? □ Low Function □ Overactive □ Goiter □ Hashimoto

12. Are you using any form of Hormone Therapy? □ YES □ NO

    If yes, please describe _____

Symptom Checklist

Please indicate how often you have the following

	Frequently	**Rarely**	**Never**			**Frequently**	**Rarely**	**Never**
Night sweats					Migraines			
Hot flashes/hot flushes					Depression			
Pain with intercourse					Anxiety			
Vaginal dryness					Decrease in sexual desire			
Sleeping problems					Decrease in energy level			
Urine leaks when you cough or sneeze					Loss of memory			
Difficulty concentrating or memory loss					Foggy thinking			
Mood swings					Muscle and/or joint pain			

Please describe the way in which these issues have been dealt with: _____

_____

_____

OB History

1. How many times have you been pregnant? _____
2. How many miscarriages have you had? _____
3. How many abortions have you had? _____
4. Have you had any Tubal/Ectopic pregnancies? _____
5. How many vaginal deliveries have you had? _____
6. How many Cesarean Sections have you had? _____
7. Have you had any premature deliveries? _____
8. Have you had any babies weighing less than 5lbs 8oz at birth? _____

OB History (continued)

9. How many full term deliveries? _____
10. Have you had any twin births? _____
11. Did you have any complications with your pregnancies? ▢ YES ▢ NO

    If YES, please list: _____

    _____

GYN History

1. Are you sexually active? □ YES □ NO
2. Have you been sexually active? □ YES □ NO
3. Do you have pain with intercourse? □ YES □ NO
4. What type of contraception are you currently using? (Please select all that apply):
   - □ Pills □ IUD □ Foam □ Condoms
   - □ Tubal Ligation □ Vasectomy □ Diaphragm □ Withdrawal
   - □ Implants □ Depo □ Provera
   - □ Other: _____
5. What type of contraception have you used in the past (Please select all that apply):
   - □ Pills □ IUD □ Foam □ Condoms
   - □ Tubal Ligation □ Vasectomy □ Diaphragm □ Withdrawal
   - □ Implants □ Depo □ Provera
   - □ Other: _____
6. Are you having any problems with your current method of birth control? □ YES □ NO
7. Have you ever had a vaginal, cervical and/or tubal infection? □ YES □ NO

   If yes, please select below all that apply:
   - □ Gonorrhea □ Yeast □ Herpes □ Warts
   - □ Gardnerella □ Syphilis □ Condyloma □ Bacterial Vaginitis
   - □ PID □ Chlamydia □ Other: _____
8. Have you ever had **cervical cancer**? □ YES □ NO

   If yes, how was it treated? _____
9. Have you ever had **uterine cancer**? □ YES □ NO

   If yes, how was it treated? _____
10. Do you have any breast lumps, tenderness or discharge? □ YES □ NO
11. Do you do self-breast exams? □ YES □ NO

GYN History (*continued*)

12. Do you have PMS symptoms? □ YES □ NO

    If yes, describe how are you currently treating symptoms: _____

13. Do you have any uterine abnormality? □ YES □ NO

14. Do you have a history of infertility? □ YES □ NO

15. Do you have a history of DES exposure? □ YES □ NO

16. Do you have fibroids of the uterus? □ YES □ NO

Medical History

1. Do you have **diabetes**? □ YES □ NO

2. Do you have or have you ever had **hypertension**? □ YES □ NO

3. Do you have **heart disease**? □ YES □ NO

4. Have you ever had a **stroke**? □ YES □ NO

5. Do you have a **heart murmur**? □ YES □ NO

6. Do you have or have you ever had **kidney disease**? □ YES □ NO

7. Have you ever been treated for a **psychiatric disorder**? □ YES □ NO

    If yes, please name the disorder: _____

8. Have you ever had **rheumatic fever**? □ YES □ NO

9. Do you have **mitral valve prolapse**? □ YES □ NO

10. Have you ever had a **urinary tract infection**? □ YES □ NO

11. Have you ever had **hepatitis**?

    If yes, which type? □ Hepatitis A □ Hepatitis B □ Hepatitis C □ Other

12. Have you ever had **liver disease**? □ YES □ NO

13. Have you ever had **varicose veins**? □ YES □ NO

14. Have you ever had **phlebitis**? □ YES □ NO

15. Have you ever had a **blood transfusion**? □ YES □ NO

16. Do you have **asthma, emphysema** or **chronic bronchitis**? □ YES □ NO

17. Do you have or have you ever had **leukemia**? □ YES □ NO

    If yes, please describe treatment: _____

Medical History (*continued*)

18. Do you have or have you ever had **lymphoma**? □ YES □ NO

    If yes, please describe treatment: _____

19. Do you have or have you ever had **colon cancer**? □ YES □ NO

    If yes, please describe treatment: _____

20. Do you have or have you ever had **colon polyps**? □ YES □ NO

    If yes, please describe treatment: _____

21. Do you have or have you ever had **multiple myeloma**? □ YES □ NO

    If yes, please describe treatment: _____

22. Do you have or have you ever had **lung cancer**? □ YES □ NO

    If yes, please describe treatment: _____

23. Do you have or have you ever had **rectal cancer**? □ YES □ NO

    If yes, please describe treatment: _____

24. Have you ever had any problems with your blood? □ YES □ NO

    If yes, please list the problem (such as anemia or excess blood cells): _____

25. Please list all **major surgeries, operations** and **hospitalizations** (including year and reason):

_____

_____

26. Have you ever had any **anesthesia complications**? □ YES □NO

    If yes, please describe: _____

27. Have you ever had your **cholesterol** checked? □ YES □NO

    If yes, what was the date it was last checked? _____

    How was your cholesterol? □ Low □ Normal □ High

28. Do you have **arthritis**? □ YES □NO

    If yes, please describe: _____

29. Do you have **lupus**? □ YES □NO

30. Do you have **scleroderma**? □ YES □NO

31. Do you have **rheumatoid arthritis**? □ YES □NO

32. Have you had **blood clots** in your legs or lungs? □ YES □NO

33. Do you have problems with **water retention**? □ YES □NO

34. Do you have problems with **swelling**? □ YES □NO

Medical History (*continued*)

35. Do you have problems with **bloating**? □ YES □NO

36. Do you have **osteopenia**? □ YES □NO

If yes, please describe treatment: _____

37. Do you have **osteoporosis**? □ YES □NO

If yes, please describe treatment: _____

38. Do you suffer from **hair loss**? □ YES □NO

39. Do you suffer from or have you had **acne**? □ YES □NO

Social History

1. Do you smoke cigarettes? □ YES □NO

Average number smoked per day: _____ How many years have you been smoking? _____

2. Do you use recreational drugs? □ YES □NO

3. Do you drink alcohol? □ YES □NO

If yes, what type of alcohol do you drink? _____

How many drinks per week, on average, do you drink? _____

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Family History

1. Please circle **YES** for those that apply to **YOUR FAMILY** (on both your mother's/maternal or father's/paternal side). Next to each statement please list the relationship to you.

		If **YES**, who in your family history?
Alcoholism	**YES NO**	
Anemia	**YES NO**	
Arthritis	**YES NO**	
Asthma	**YES NO**	
Cancer of the breast	**YES NO**	
Cancer of the colon	**YES NO**	
Cancer of the ovaries	**YES NO**	
Cancer of the prostate	**YES NO**	
Cancer of the uterus	**YES NO**	
Cancer, other unspecified	**YES NO**	
Colon polyps	**YES NO**	
Depression	**YES NO**	
Diabetes	**YES NO**	
Glaucoma	**YES NO**	
Heart disease (CAD)	**YES NO**	
Elevated Cholesterol	**YES NO**	
Hypertension	**YES NO**	
Osteoporosis	**YES NO**	
Pulmonary embolism/DVT	**YES NO**	
Stroke	**YES NO**	
Thyroid disease	**YES NO**	

2. At what age did your mother go through menopause? _____

Physician Signature _____ Date _____

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