

# Riley Perry Lloyd, MD, FACOG

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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

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4905 Old Orchard Center, Suite #330  
Skokie, IL 60076

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

**Phone: 847.763.7100 | Fax: 847.763.7102**

**PATIENT REGISTRATION FORM: FEMALE**

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: \_\_\_\_\_

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

If yes, please list drugs you are allergic to: \_\_\_\_\_

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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: \_\_\_\_\_

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### 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 prolepses**?  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  NO36. 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  NO39. Do you suffer from or have you had **acne**?  YES  NO**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	<b>YES</b> <b>NO</b>	
Anemia	<b>YES</b> <b>NO</b>	
Arthritis	<b>YES</b> <b>NO</b>	
Asthma	<b>YES</b> <b>NO</b>	
Cancer of the breast	<b>YES</b> <b>NO</b>	
Cancer of the colon	<b>YES</b> <b>NO</b>	
Cancer of the ovaries	<b>YES</b> <b>NO</b>	
Cancer of the prostate	<b>YES</b> <b>NO</b>	
Cancer of the uterus	<b>YES</b> <b>NO</b>	
Cancer, other unspecified	<b>YES</b> <b>NO</b>	
Colon polyps	<b>YES</b> <b>NO</b>	
Depression	<b>YES</b> <b>NO</b>	
Diabetes	<b>YES</b> <b>NO</b>	
Glaucoma	<b>YES</b> <b>NO</b>	
Heart disease (CAD)	<b>YES</b> <b>NO</b>	
Elevated Cholesterol	<b>YES</b> <b>NO</b>	
Hypertension	<b>YES</b> <b>NO</b>	
Osteoporosis	<b>YES</b> <b>NO</b>	
Pulmonary embolism/DVT	<b>YES</b> <b>NO</b>	
Stroke	<b>YES</b> <b>NO</b>	
Thyroid disease	<b>YES</b> <b>NO</b>	

**Family History (continued)**

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

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**Social History**

1. Do you smoke cigarettes?  YES  NO

If yes, please list the 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? \_\_\_\_\_

**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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