PATIENT REGISTRATION FORM

Revised 04/2012

PATIENT INFORMATION

Name: (First, MI, Last)		Sex	Home Phone:	
Address: (Street#)			Social Security #:	
City, State		Zip	DOB	Marital Status
Employer	Job Title		Work phone #:	Cell phone #:
Name and phone number of emergency contact				
Email Address:			May we correspond by email? ☐ Yes ☐ No	

REFERRING PHYSICIAN INFORMATION

Referred by:	Office Phone #:
Address	

FINANCIAL RESPONSIBILITY

Name of person financially responsible: (if patient is a minor)		Relationship to Patient:
Address: (Street#, City, State, Zip) ** If different than patient**		
Phone #	DOB	Social Security #

INSURANCE INFORMATION

Primary Insurance carrier	Group #	ID #	
Policy Holder's Name (First, MI, last)	PCP Co-pay amount	Specialist Co-pay amount	
Address: (Street#, City, State, Zip) ** If different than patient**			
Phone #	Relationship	DOB	Sex
Employer	Social Security#	Effective date of insurance	
Secondary Insurance carrier	Group #	ID #	
Policy Holder's Name		Relationship to patient	

_____ _____

Patient Signature Date

ADULT PATIENT HEALTH HISTORY

The information completed on this questionnaire will become a confidential part of your medical record.

Today's Date: ____/____/____

Name: _____ Date of birth: ____/____/____
Last First Middle

Reason for visit: _____

Current symptoms: _____

MEDICAL HISTORY

ILLNESSES:

Check major, significant illnesses which apply to you:

- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding/Blood Disorder
- ☐ Breast cancer
- ☐ Cancer(s) _____
- ☐ Cataracts
- ☐ Colitis
- ☐ Depression
- ☐ Constipation
- ☐ Emotional/Mental Illnesses
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Problems
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Mononucleosis
- ☐ Polymyalgia Rheumatica (PMR)
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis/TB
- ☐ Rheumatoid Arthritis
- ☐ Lupus

SURGICAL:

List the year of any operations/procedures you have had.

	Date		Date
Appendix Surgery	_____	Hip Surgery	_____
Breast growth removal	_____	Hysterectomy	_____
Carpal tunnel	_____	Knee Surgery	_____
Cataract Removal	_____	Nasal/Sinus Surgery	_____
Cesarean section delivery	_____	Plastic Surgery	_____
Colonoscopy (looking into bowel)	_____	Polyp removal from intestine	_____
D & C	_____	Prostate surgery	_____
Gall bladder surgery/laparoscopy	_____	Thyroid surgery	_____
Gastroscopy (looking into stomach)	_____	Tonsils/Adenoids removed	_____
Heart catheterization/surgery	_____	Tubal Ligation	_____
Hernia	_____	Vasectomy	_____
		Other	_____

MEDICATIONS

List all medications you are currently taking which have been ordered by a doctor (including inhalers) and all over the counter drugs, vitamins or herbs. Please list prescribed medications first,

YOUR PHARMACY NAME AND LOCATION: _____ Phone_____

Name of Medicine/Dose/Frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

IMMUNIZATIONS:

Date of most recent:

_____ Flu (once annually)
_____ Pneumonia (Once every 5 years)
_____ Tetanus
_____ Shingles

ALLERGIES

☐ Medications: List/Describe: _____

_____

☐ Food ☐ Animals ☐Latex ☐Tape ☐ Pollens ☐ Eggs ☐ Iodine ☐ Nuts
Other: _____

SOCIAL HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partner

What is your smoking status? ☐ Never ☐Past ☐Current

a. Year Quit: _____
b. Number of years smoked: _____
c. Average number of packs/day: ____ ☐ Chewing tobacco ☐Cigarettes
d. Would you like help to quit? ☐ Yes ☐ No

On average, how many alcoholic drinks (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz liquor) do you consume? ☐ Non-drinker ☐ 1-2 per week ☐ 1-2 per day ☐ 3 or more per day ☐ other_____

a. Do you drink every day? ☐ Yes ☐ No
b. Have you ever thought you had a problem with drinking? ☐ Yes ☐ No

Any street drug use? ☐ Yes ☐ No If yes, substance? _____, how long? _____

FAMILY HISTORY

RELATIVE'S DEATHS:

List the cause of death and age at death if applicable:
Father: _____ Mother's father: _____ Father's father: _____
Mother: _____ Mother's mother: _____ Father's mother: _____
Any Sibling: _____

FAMILY ILLNESSES:

Check any illnesses which have occurred in a blood related brother (b), sister (s), mother (m), father (f) or grandparent (g):

	WHO		WHO
☐ Alcoholism/Substance Abuse	_____	☐ Emotional/Mental Illness/Suicide	_____
☐ Alzheimer's/Dementia	_____	☐ High Blood Pressure	_____
☐ Cancer (Breast)	_____	☐ Heart attack prior to age 50	_____
☐ Cancer (Colon)	_____	☐ Osteoporosis	_____
☐ Cancer (Prostate)	_____	☐ Stroke	_____
☐ Cancer (other) _____	_____	☐ Arthritis	_____
☐ Diabetes	_____		

OTHER PHYSICIANS:

List any other doctors (specialists, etc.) you have seen:

_____
_____

Review of Systems

Name: _____ Date: _____

DOB:_____

Please circle yes or no. If yes, please explain:

Neurological

Y or N Do you have numbness or tingling in the hands or feet? If yes, is it at night? _____

Y or N Do you have memory loss?

Y or N Do you have double vision?

Y or N Do you have slurred speech?

Y or N Do you have temporary loss of vision?

Y or N Have you ever had a loss of use of an arm or leg?

Rheumatologic (arthritis) questions:

Y or N Fatigue?

Y or N Malaise (feeling ill)?

Y or N Recent weigh loss or gain (in the last 6 months)?

Y or N Recent chills ,fever, or increased temperature?

Y or N Night sweats (drenching bed sheets by perspiring)?

Y or N Insomnia (inability to sleep)?

Y or N Morning stiffness? For how long?

Y or N Muscle weakness (difficulty walking stairs, getting out of chair or lifting light packages)?

Y or N Joint pain?

Y or N Joint swelling? Which joints?

Y or N Have you ever had a swollen joint as a child or teenager?

Y or N History of broken bones?

Y or N Headaches ? How often?

Y or N Scalp tenderness when combing hair?

Review of Systems

Y or N Jaw pain?

Y or N Neck pain?

Y or N Low back pain?

Y or N Do your hands change color in the cold weather?

Y or N Sun sensitivity (skin rash when exposed to the sun)?

Infectious disease- Please circle if you have had:

Measles	Chicken pox	Hepatitis
Influenza	Diphtheria	Scarlet Fever
Mononucleosis	Rheumatic Fever	Fungus
Mumps	Whooping cough	
Polio	Typhoid Fever	
Tuberculosis	Parasites	

Have you ever been tested for:

HIV _____

Hepatitis_____

Tuberculosis _____ Date of last tuberculin test: _____ Result: Pos or Neg

Cardiac (heart):

Y or N Chest pain?

Y or N Shortness of breath? If yes, with exercise? _____

Y or N Angina pectoris?

Y or N Have you ever been told you have a heart murmur? EKG_____

Y or N Heart attack? Stress test _____

Y or N Do your ankles swell? Cardiac Cath_____

Y or N High blood pressure?

Review of Systems

Pulmonary (lung or breathing)problems

Y or N Morning cough?

Y or N Morning sputum (phlegm production)?

Y or N Hemoptysis? (coughing up bloody phlegm)?

Y or N History of asthma?

Y or N Chest pain?

Y or N Have you ever had pleurisy of pneumonia?

Y or N Do you smoke? If so, Cigarettes, Cigar or Pipe (circle one)

Y or N Have you ever smoked? If so When_____ How much_____ How long_____

Date of last chest x-ray? _____

Urinary

Y or N Do you have frequent urinary tract infections?

Y or N Have you ever had prostatitis?

Y or N Do you have burning with urination?

Y or N Do you ever have blood in your urine?

Y or N Do you wake up during the night to urinate?

Y or N Have you ever had kidney stones?

Menstrual history (females only)

Age of onset of menstruation: _____

Age of onset of menopause: _____

Last pelvic exam: _____

Last Pap Smear:_____

Y or N Have you had a mammogram (X-rays of the breast)? _____

Y or N Have you had a hysterectomy? If so, why? _____

Y or N Have you ever had vaginal ulcers (herpes)?

Review of Systems

Sexual History

Y or N Do you have pain with intercourse?

Y or N Do you have impotence?

Y or N Do you have loss of libido (interest)?

Y or N Have you ever had venereal disease?

Y or N Have you ever had penile drip? (Men only)

Gastrointestinal

Y or N Do you have stomach pain after eating?

Y or N Do you take antacids?

Y or N Have you ever had bowel disease such as Crohn's or regional enteritis?

Date of last colonoscopy_____

Y or N Do you have abdominal cramps?

Y or N In the morning?

Y or N At night?

Y or N Do you have diarrhea? How often? _____

Y or N Do you have hemorrhoids?

Y or N Do you have problems with constipation?

Y or N Do you drink alcohol?

How much _____drinks per_____ day or week (circle)

For how many years_____

Y or N Have you ever had gallbladder disease?

Y or N Have you had pancreatic disease?

Review of Systems

Psychological history

Have you had a change in your lifestyle recently such as:

__ Divorce

__ Separation

__ Marriage

__ Move

__Change in job

__Childbirth

__ Change in household (relatives moving in etc.)

__ Death of a loved one

__Business set back

Patient signature:_____ Date:_____

Physician signature: _____ Date: _____

Review of Systems