

Las Cruces Surgeons Group
925 S. Walnut, Las Cruces, NM 88001
575-523-6330



REGISTRATION FORM, i693 Physical

Birthdate:

Patient's Legal Name:

Marital Status (circle): Single / Married / Divorced / Separated / Widowed

Who lives at home with you?

Mailing Address

Phone Number:

City:

State:

Zip:

Occupation:

Medical diagnoses:

Prescription Medications:

Past Hospitalizations/Surgeries:

Drug Allergies:

Do you smoke? NO YES Packs per day:

Do you drink? NO YES Drinks per week:

Signature:

Date:

Las Cruces Surgeons Group

Medical History: Please check any conditions that are a **SIGNIFICANT** problem for you.

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain with activity		Burning or painful urination	
Recent weight change		Hear skips beats		Frequent urination	
Fatigue		Heart beats too fast		Blood in urine	
Heat or cold intolerance		Passing out spells		Bladder infections	
Head and Neck	YES	High blood pressure		Incontinence or dribbling	
Swelling in neck		Heart murmur		Kidney Stones	
Prolonged hoarseness		Bad heart valve		Change in stream	
Sore throat		Rheumatic fever		Irregular menses	
Pain or stiffness in neck		Feet or ankle swelling		Gastrointestinal	YES
Skin	YES	Short of breath at rest		Rectal bleeding	
Rash, dryness itching		Short of breath with exercise		Blood in stool	
Change in nails or skin color		Short of breath lying down		Loss of appetite	
Bleeding, bruising tendencies		Lungs	YES	Heartburn or indigestion	
Eyes	YES	Cough		Chronic abdominal pain	
Glasses or contacts		Cough with sputum or blood		Chronic constipation	
Double, failing vision		Wheezing		Black or tarry stools	
Dry eyes		Musculoskeletal	YES	Frequent diarrhea	
Pain or light sensitivity		Swollen or red joints		Difficulty swallowing	
Ears, Nose, Mouth		Arm or leg weakness		Nausea or vomiting	
Loss of smell		Leg Cramps		Vomiting of blood	
Nose Bleeds		Difficulty in walking		Endocrine	YES
Sinus problems		Neurologic	YES	Night sweats	
Runny Nose		Lightheaded or dizziness		Excessive thirst	
Postnasal drip		Speech disturbances		Psychiatric	YES
Earache or drainage		Convulsions or seizures		Depression	
Hearing loss		Numbness or tingling		Anxiety	
Ringling in ears		Frequent headaches		Nervous breakdown	
Dentures		Memory loss		Alcohol problems	
Sores in mouth		Paralysis or weakness		Physical, verbal, sexual abuse	
		Sleep disorders		Drug Problems	

Past and Family History: Please check if you or your family have ever had any of the following

	You	Family		You	Family		You	Family
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Blood Disorders			Vision Problems		
Renal Disease			Lupus			Hearing Problems		
Ulcerative Colitis			Stroke			Glaucoma		
Other			Other					

CANCER TYPE: _____

Signature:

Date:
