REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone:		
Mobile Phone:	**Other Phone:**	
Patient e-mail:		
Date of Birth:	**Sex:** ☐ Male ☐ Female	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Unknown		
Race: ☐ Black/African American ☐ Asian ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic		
Primary Language: ☐ English ☐ Spanish ☐ Other: _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: ☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	**State:**	**Zip code:**
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	**Effective Date – From:**
Subscriber Name:	**Patient's Relationship to Insured:**
Subscriber SSN:	**Subscriber's DOB:**
Subscriber Employer:	**Subscriber's Sex:** ☐ Male ☐ Female

History Form – Primary Care

What name do you like to be called?_____

What is the best number to reach you during the day? ( )_____-_____

May we leave a brief message? □ Yes □ No

Medical History: Have you ever been treated for any of the following medical conditions?

□ No changes
□ Arthritis
□ Diabetes
□ High blood pressure
□ Irritable bowel
□ Osteoporosis
□ Cancer
□ Depression/anxiety
□ Heart problems
□ High cholesterol
□ Lung problems
□ Thyroid problems

Please list any additional medical conditions:

_____

Have you ever been hospitalized overnight? □Yes □No

Have you ever had surgery? □ Yes □ No _____

_____

Medications and Allergies will be reviewed by clinic staff.
(Please bring your bottles with you or a complete list of everything you take on a regular basis.)

Do you take any supplements (calcium/vitamin D/fish oil/multivitamin)? □Yes □ No

Family History: Please list any known medical problems for the relatives listed below:

For example: diabetes, breast/colon/ovarian/ prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis.

□ No changes

Mother:_____

Father:_____

Brothers/Sisters:_____

Children:_____

Other:_____

_____

_____

Habits:

What do you do for exercise?_____

How often?_____

Tobacco (chew / smoke): _____per day

Alcohol (beer / wine, etc.):_____ per day

Street Drugs (marijuana, etc.):_____

Caffeine (coffee / tea / soda):_____ per day

Any trouble sleeping? □ Yes □ No

Describe your eating habits: (poor, well-balanced, vegetarian, gluten-free, etc.)_____

Do you eat out more than twice a week? □ Yes □ No

Social History:

Are you retired? □ Yes □ No

Work Type:_____

Do you enjoy your job?_____

Any major stresses in your life?

_____

_____

_____

Relationship Status:

□ Married □ Single □ Widowed

□ Divorced/Separated

□ In a relationship

How long?_____

Who do you live with:_____

How many children do you have?

_____

Do you feel you ever have been abused (verbally, physically, or sexually? □ Yes □ No

Do you wear seatbelts/helmets?

□ Yes □ No □ Sometimes

Do you wear sunscreen?

□ Yes □ No □ Sometimes

Do you have an eye exam at least every two years?

□ Yes □ No

Do you have a dental exam at least yearly? □ Yes □ No

Continue on back.....

REVIEW OF SYSTEMS

Please circle any current symptoms below:

General Symptoms:
Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out

Eyes:
Vision loss, eye pain, blurred vision

Ears/Nose/Mouth & Throat:
Sore throat, runny nose, hearing loss, problems with mouth, voice changes

Breasts:
Lumps, skin changes, nipple discharge

Lungs & Heart:
Chest pain/pressure, irregular heart beat, cough, wheezing, breathing trouble

Skin:
Rashes, changing moles, changes in hair/skin/nails

Neurological:
Unusual or new headaches, weakness or numbness, falling

Abdomen:
Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools

Sleep:
Difficulty falling asleep, frequent awakening

Musculoskeletal:
Joint/muscle pain, muscle weakness

Mood:
Worry too much, felt down and depressed in the last two weeks, loss of desire to do things you used to enjoy, thoughts of self harm or suicide

Men Only:
Difficulty starting or weak stream, difficulty getting/maintaining erections, feeling like bladder won't empty, getting up at night to urinate, testicular pain/lumps, possible sexually transmitted infections

Women Only:
Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine

Period Questions:
Still having periods? □ Yes □ No
□ Regular □ Irregular
Date of last period:_____
Birth Control type:_____
Hysterectomy: □ Yes □ No
If yes, what age?_____
Due to what?_____
Number of pregnancies:_____
_____ Vaginal deliveries
_____ C-section deliveries
_____ Other (stillbirth, miscarriage/abortion)
Diabetes in pregnancy? □Yes □ No
Have you ever had an abnormal pap or colposcopy? □ Yes □ No

Other:
List any symptoms not mentioned:
_____
_____
_____

*******The following will be completed and used by clinic staff:*******

Prevention

Women:
Last Pap Test:_____
Chlamydia Screening:_____
Mammogram:_____
Bone Density:_____

Men:
PSA Screening:_____

Everyone:
Colonoscopy:_____
Lipid Panel:_____
Fasting Glucose_____ HgbA1c_____

Immunizations:
Tdap:_____ Zostavax:_____
Pneumovax:_____ Influenza:_____
Gardasil:_____