ALCHEMI RESEARCH

New Patient Registration – Medical Information

Patient Name: First_____Middle_____Last_____

Date of Birth:_____/_____/_____

Who are your current medical providers?	
Provider name	Specialty, or condition for which they treat you

Preventive Care					
	Date		Date		Date
Annual physical		Prostate screen		Cholesterol test	
Colonoscopy		Pap screen		Diabetes screen	
Bone density		Mammogram		Eye exam	
Dental exam					

Immunizations					
	Date		Date		Date
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		Other :	

Allergies or intolerances to medications?	
Name	Reaction

Please list all medications, supplements, over the counter drugs, creams and inhalers.				
Name	Medical Condition	Dose/Strength	Frequency taken	Start Date

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Please check all current or past medical problems or conditions.		
☐ Heart Failure	☐ High Blood Pressure	☐ ADD/ADHD
☐ Chronic Lung Disease	☐ Hyperthyroidism	☐ Seasonal Allergies
☐ Heart Artery Disease	☐ Hypothyroidism	☐ Anemia
☐ Depression	☐ Kidney Disease	☐ Anxiety
☐ Diabetes Type 1	☐ Migraines	☐ Arthritis
☐ Diabetes Type 2	☐ Heart Attack	☐ Asthma
☐ Emphysema	☐ Stomach/Intestine Ulcers	☐ Bipolar Disorder
☐ Heartburn	☐ Seizures	☐ Blood Clots
☐ Glaucoma	☐ Sexually Transmitted Infection	☐ Blood Transfusion
☐ Heart Murmur	☐ Stroke	☐ Cancer
☐ HIV/AIDS	☐ Substance Abuse	☐ Cataracts
☐ High Cholesterol	☐ Valley Fever	

Please check all major operations or surgeries.		
☐ None	☐ Colon	☐ Joint Replacement
☐ Appendectomy	☐ Coronary Artery Stent	☐ Spine
☐ Breast Augmentation	☐ Cosmetic Surgery	☐ Thyroid Surgery
☐ Breast Surgery	☐ Eye	☐ Tonsillectomy
☐ Cesarean Section	☐ Fracture Repair	☐ Tubes Tied
☐ Heart Bypass	☐ Hernia repair	☐ Heart Valve surgery
☐ Gallbladder	☐ Hysterectomy	☐ Ovaries

Family Medical History – Please check the appropriate box if a condition is/was present.

	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	High Cholesterol	High Blood Press	Kidney Disease	Mental Illness	Miscarriages	Stroke	Vision Loss	Alzheimer	Other
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Patient Name: First_____Middle_____Last_____Date of Birth:____/____/____

Social History	
Alcohol Use – Please check your response.	
Glasses of wine per week	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10+
Cans of beer per week	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10+
Shots of liquor per week	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10+
Mixed drinks with 0.5 ounces alcohol per week	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10+
Sexual Activity – Please check your response.	
Sexually active? ☐ Currently ☐ Never ☐ Not Currently	
Sexual Partners? ☐ Men ☐ Women ☐ Both	
Birth control used? ☐ Pulling out ☐ Condom ☐ Diaphragm ☐ Implant ☐ Inserts ☐ IUD ☐ The Pill ☐ Patch ☐ Rhythm ☐ Spermicide ☐ Sponge ☐ Surgical ☐ Not applicable	
Drug Use – Please check your response.	
☐ None ☐ Amphetamines ☐ Benzodiazepines ☐ "Crack" Cocaine ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Methamphetamines ☐ PCP ☐ Huff Gasses	
Tobacco Use – Please check your response.	
☐ Smoke every day ☐ Smoke some days ☐ Former smoker ☐ Heavy smoker ☐ Light smoker ☐ Never smoked ☐ Second-hand exposure	
If ever smoked, how many packs/day average? ☐ ½ ☐ 1 ☐ 1½ ☐ 2 ☐ 3 or more How many years smoked?	
You ever chewed? ☐ Yes ☐ No	
If you currently use any tobacco product, are you ready to quit? ☐ Yes ☐ No	

Hospitalizations		
Reason	Year	Comments

Major Injuries		
Type	Year	Comments

Advance Directives (Living will and medical power of attorney)		
Do you have an advance directive?	☐ Yes	☐ No
Would you like information or a copy of advance directive forms?	☐ Yes	☐ No

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Sex: ☐ M | ☐ F

Demographics and Insurance

Patient street address: _____

Patient address additional: _____

City:_____State:_____ZIP:_____-_____

Primary Phone Number: (_____)_____-_____☐Mobile | ☐Home | ☐Work

Secondary Phone Number: (_____)_____-_____☐Mobile | ☐Home | ☐Work

Email address: _____

What is your primary language?_____Interpreter Required? ☐ Yes | ☐ No

Marital Status: ☐ Single
☐ Divorced
☐ Legally Separated
☐ Married
☐ Other
☐ Sig. Other
☐ Widowed

Religious preference:_____ ☐ I prefer not to answer.

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity?
   ☐ Hispanic or Latino ☐ Not Hispanic or Latino
   ☐ I prefer to not answer.

2. How do you identify your race?
   ☐ American Indian or Alaska Native ☐ Black or African American
   ☐ Native Hawaiian ☐ Other Pacific Islander
   ☐ White or Caucasian ☐ Asian
   ☐ I prefer to not answer

Who is your primary care physician? _____

Name of the primary care practice: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

Employer Name: _____

How many employees work at your company? ☐ 1-19 ☐ 20-99 ☐100+ ☐ Don't know

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Who would you like to list as an **emergency contact**?

Name: _____

Address: _____

_____

Relationship to you: _____

Phone Number: (_____)_____-_____