ACCESS HEALTH
Concierge Care
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SEBASTOPOL
URGENT CARE
www.sebuc.org | (707) 509-5961

Access Health Patient Registration Form

Practice: (circle one) Urgent Care Bohemian Concierge Care Compassionate Concierge Care

Medical History Form

Date:________________

*Patient Name:*____

Last: First: Middle:

Reason Visit:

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Medication List *(you may use reverse side:*

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Pharmacy:

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Name: Phone: Address:

Allergies:

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*List of Surgeries:*____

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Have you ever had any of the following? (Please circle all that apply)

EMG CT Scan Myelogram MRI X-RAY

Have you ever, or are you presently being treated for any of the following conditions?

Please Check all that Apply:	Yes	No
Acquired Respiratory Distress Syndrome		
Angina		
Anxiety or panic disorders		
Arthritis (RA, OA)		
Asthma		
Chronic Obstructive Pulmonary Disease (COPD)		
Congestive Heart Failure (CHF)		
Degenerative Disc Disease (Back disease, spinal stenosis, severe chronic back pain		
Depression		
Diabetes		
Emphysema		
Hearing Impairment		
Heart Attack		
Multiple Sclerosis		
Osteoporosis		
Parkinson's Disease		
Peripheral Vascular Disease		
Stroke or TIA		
Upper Gastrointestinal Disease (ulcer, hernia, reflux)		
Visual Impairment (cataracts, glaucoma, macular, degenerative)		

Please Check all that Apply:	Yes	No
Allergies		
Headaches		
Back Injuries		
Bleeding Disorders		
Bowel/Bladder Abnormalities		
Cancer		
Dizzy or Fainting Spells		
Epilepsy or Seizure Disorder		
Fracture		
Hepatitis A, B, C		
Hernia		
High Blood Pressure		
Hypoglycemia		
Immunosuppressant Condition or Medication		
Kidney Problems		
Liver/ Gallbladder Problems		
Metal Implants		
Nausea Vomiting		
Pacemaker		
Pregnancy		
Ringing in your Ears		
Sexual Dysfunction		
Skin Abnormalities		

Is there any other information regarding your medical history that we should know about?

____

Signature of Patient or Guardian (if patient is a minor):______________________________

Print Name:____

Relationship to Patient