

# Patient Registration Form

Date of Appointment: \_\_\_\_\_

## Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age) ( )		Social Security Number	
Patient's Address ,			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone		Pharmacy Address ,		

## Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address ,			City	State	Zip

## Emergency Contact Information

Emergency Contact Name		Emergency Contact Phone	Relation to Patient		
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## Billing and Insurance

### Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	
Insured's Address ,			City	State	Zip
Insured's Social Security Number	Insured's Birthdate				

### Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number		
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	

### Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address ,			City	State	Zip

\_\_\_\_\_  
Signature of Patient or Authorized Guardian

\_\_\_\_\_  
Date

Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

**Reason for Visit**

What brings you to the office today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How is your general health?

Excellent  Good  Fair  Poor

Do you have any other concerns you would like to address?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications**

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies**

Are you allergic to any of the following?

- Adhesive Tape
- Barbiturates (Sleeping Pills)
- Codeine
- Antibiotics
- Aspirin
- Sulfas
- Latex
- Iodine
- Local Anesthetics

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

**Past Medical History**

- |   |  |  |   |  |   |
|---|--|--|---|--|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Back Problems     | <input type="checkbox"/> Ear Problems    | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Measles         | <input type="checkbox"/> Skin Disorder    |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Migraines       | <input type="checkbox"/> Stomach Ulcer    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Substance Abuse  |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Joint Disorder         | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Gout            | <input type="checkbox"/> Kidney Disorder        | <input type="checkbox"/> Polio           | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Liver Disorder         | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS / HIV       | <input type="checkbox"/> Depression        | <input type="checkbox"/> Heart Problems  | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stroke          |   |

**Hospitalizations & Surgeries**

Reason	Date
_____	_____
_____	_____

**Women Only:**

# of Pregnancies \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Abortions \_\_\_\_\_ # of Living \_\_\_\_\_

Last Pap Smear \_\_\_\_\_ Last Mammogram \_\_\_\_\_ Birth Control Method \_\_\_\_\_

**Family History**

Has anyone in your family ever had any of the following conditions?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Joint Disorder        |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Depression          | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Alzheimer's       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Liver Disorder        |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Lung Disease          |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Genetic Disorder    | <input type="checkbox"/> Migraines             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Stroke Substance      |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Abuse                 |
| <input type="checkbox"/> Blood Disorder    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder      |

Details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Lifestyle Factors**

Are you sexually active?

Yes  No # of partners in past year \_\_\_\_\_

Do you wish to be checked for STDs?

Yes  No

Has anyone in your home ever physically or verbally hurt you?

Yes  No

Have you ever smoked?

Yes  No # of years \_\_\_\_\_ # packs/day \_\_\_\_\_

Do you smoke now?

Yes  No # packs/day \_\_\_\_\_

Do you use recreational drugs?

Yes  No types? \_\_\_\_\_ # times/week \_\_\_\_\_

How much alcohol do you drink per week?

# drinks/week \_\_\_\_\_

How much caffeine do you drink per day?

# drinks/day \_\_\_\_\_

How often do you exercise?

# times/week \_\_\_\_\_

Name \_\_\_\_\_

Gender \_\_\_\_\_

Age \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

### Review of Systems

#### General

- Chills
- Dizziness
- Fainting
- Fever
- Hair Loss
- Hair Growth – Excessive
- Night Sweats
- Sleeping Problems
- Thirst - Excessive
- Weight Gain
- Weight Loss

#### Mental Health

- Anxiety
- Depression
- Loss of Interest
- Feeling Hopeless
- Hearing Voices
- Marital Problems
- Panic Attacks
- Trouble Concentrating
- Suicide –Thoughts/Attempts

#### Skin

- Acne
- Bruise Easily
- Changes in Moles
- Chills
- Dry / Sensitive Skin
- Eczema
- Hives
- Itching
- Rash
- Scars
- Sores That Won't Heal

#### Gastrointestinal

- Appetite Gain
- Appetite Loss
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Intestinal Disorder
- Lactose Intolerance
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

#### Genitourinary

- Blood in Urine
- Lack of Bladder Control
- Frequent Urination
- Painful Urination

#### Neurological

- Coordination Problems
- Convulsions
- Difficulty Walking
- Learning Disabilities
- Light-headedness
- Memory Loss
- Numbness / Tingling
- Paralysis
- Seizures
- Speech Problems
- Tremors

#### ENT

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earaches
- Ear Discharge
- Hay Fever
- Hoarseness
- Hearing Loss
- Nose-Bleeds
- Persistent Cough
- Persistent Runny Nose
- Recurring Sore Throat
- Ringing in Ears
- Sinus Problems
- Vision Halos

#### Respiratory

- Coughing Coughing
- Up Blood
- Shortness of Breath
- Wheezing

#### Cardiovascular

- Chest Pains
- Irregular Heart Beat
- Circulation Problems
- Heart Palpitations
- Rapid Heartbeat
- Swelling of Ankles
- Varicose Veins

#### Musculoskeletal

- Back Pain
- Carpal Tunnel Syndrome
- Joint Pain
- Joint Swelling
- Neck Pain
- Shoulder Pain

#### Men Only

- Erection Difficulties
- Lump in Testicles
- Penile Discharge
- Sore on Penis

#### Women Only

- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge

#### Other Symptoms

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

<input type="checkbox"/> Cholesterol Test	Month & Year _____	<input type="checkbox"/> MRI	Month & Year _____
<input type="checkbox"/> Colonoscopy	_____	<input type="checkbox"/> Physical Exam	_____
<input type="checkbox"/> CT/CAT Scan	_____	<input type="checkbox"/> Cardiac Stress Test	_____
<input type="checkbox"/> EKG	_____	<input type="checkbox"/> Ultra Sound	_____
<input type="checkbox"/> Echocardiogram	_____		

### Immunizations

Please check and date all immunizations you have had.

<input type="checkbox"/> Hepatitis A	Month & Year _____	<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	Month & Year _____
<input type="checkbox"/> Hepatitis B (Series of 3)	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> HPV Vaccine	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Influenza (Flu Shot)	_____	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Meningitis	_____		