Patient Registration

Name	Marital Status S M W D Sep	Today's Date	Date of Birth
Street	City, State, Zip		
Phone (Home #) (Work #) (Cell #) Occupation/Employer			
Spouse's Name	Date of Birth	Employer	
Emergency Contact (Other Than Spouse)	Phone	Address	Relation

Health Questionnaire

Reason for Visit

Family History Please note if any blood relative has any of the following conditions.

Condition	Relative(s)	Condition)	Relative(s)
Epilepsy		Osteoporosis	
Migraine		Arthritis	
Mental Illness		Heart disease	
Glaucoma		Stroke	
Diabetes		High Blood Pressure	
Thryoid		High Cholesterol	
Hayfever		Alcoholism	
Asthma		Hepatitis	
Anemia		Cancer	
Bleeds easily		Other	

Hospital Admissions (Not Including Pregnancies)

Year	Illness or Operation	Year	Illness or Operation

Medications You Are Currently Taking (Including those you buy without a prescription)

Allergies to Medications

Supplements (Attach list if necessary)

Vaccine History

Vaccine	Year of Last	Vaccine	Year of Last
Tetanus/Td		Tdap (Tetanus, Diptheria, Whooping Cough)	
Influenza (flu)		MMR (Red Measles, Mumps, Measles)	
Pneumonia		Meningitis	
Hepatitis B		Chicken Pox	
Hepatitis C			
Whooping Cough			

Medical History Mark "C" for current problems. Check (√) and indicate age when you had any of the following.

___Decreased hearing	___Hemorrhoids ___Hernia	___Rheumatic fever ___Scarlet fever
___Ringing in ear	___Weight loss/gain ___Appetite	___Chickenpox ___Polio ___Mumps
___Ear infections - frequent	___Anemia ___Bruise easily	___Measles ___German measles
___Dizzy spells ____ Fainting spells	___Blood transfusions	___Tuberculosis ___Herpes
___Failing vision ___ Eye pain		___AIDS/HIV ___STD
Date of last eye exam _________	Urination - Overactive bladder	___Sexual problems/enjoyment
____Double or blurred vision	___Overnight more than twice	___Decreased life enjoyment
___Nose bleeds _____ Sinus trouble	___More than 8 times in 24 hours	___Decreased work performance
___Sore throats - frequent	___Urgency to urinate ___with leakage	
___Hoarseness - prolonged	___Decrease in force/flow ___painful	___Alcohol _______oz. per week
___Hayfever/Allergies	___Leakage with exercise/movement	___Coffee/Tea ____cups per day
___Pneumonia/Pleurisy	___Blood in urine ___Kidney stones	___Smoking - cig/day ____ years____
___Bronchitis/Chronic cough	___Urine infections - frequent	Year quit _______
___Asthma/Wheezing	___Bedwetting	___Exercise _______________________
Date of last TB test __________		___Street drugs _______________
___Shortness of breath:	___Decreased energy/endurance, Fatigue	___Unwanted facial hair
___on exertion ___lying flat	___Cancer Type: _____________________	Hair loss: ___Progressive ___Recent
___in the past week ___affects lifestyle	___Diabetes	
___Chest pain ___High blood pressure	___Thyroid disease	MALES ___Prostate Problems
Date of last cholesterol test _______	___Seizures ___Stroke	
___Heart murmur ___ Swollen ankles	___Tremor/hands shaking	FEMALES - Please complete
___Irregular pulse ___ Palpitations	___Headaches ___Numbness: Where____	Menstrual flow:
___Leg pain - when walking	___Arthritis/Rheumatism	___Reg. ___Irreg. ___Pain/Cramps
___Varicose veins/Phlebitis	___Bone fracture/joint injury	Days of flow____ Days in cycle _____
___Cold numb feet	___Osteoporosis ___Back pain	Date - 1st day of last period________
___Loss of appetite - recent	___Foot pain ___Gout	Number of:
___Difficulty swallowing	___Rashes ___Hives	Pregnancies ____ Abortions_____
___Heartburn ___Peptic ulcer	___Psoriasis ___ Eczema	Miscarriages _____ Live births _____
___Aspirin/Arthritis/Pain pills	___Concentration problems	Birth control method ______________
___Nausea/vomiting ___Gallbladder problems	___Depression ___Nervousness	Name of b.c. pill ________________
___Jaundice/Hepatitis	___Agitation ___Memory loss	____Flushing/Menopause
___Irritable bowel syndrome	___Moodiness ___Suicidal thoughts	____Pain/Bleeding during or after sex
___Abdominal pain ___Bloating/discomfort	___Feelings of worthlessness	____Migraine ___with nausea
___Diarrhea ___Constipation	___Phobias ___Mental illness	Date of last Pap test __________
___Diverticulosis ___Crohn's ___Colitis	___Sleep problems - how long______	___normal ___abnormal
___Inflammatory bowel disease	How frequent __________	Date of last mammogram _________
___Bloody/tarry stools	Not waking refreshed_____	___normal ___abnormal
Test for blood in stools _______		

Notes