



# Patient Registration Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_ Email Address: \_\_\_\_\_  Male  Female

Race: \_\_\_\_\_ Latino  Yes  No Language Spoken: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_ Spouse SS#: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

How would you like to be contacted by our office  Phone  Email

Referring Doctor: \_\_\_\_\_ Other Providers: \_\_\_\_\_

Prescription Drug Plan:  Yes  No Pharmacy Preference (include location) \_\_\_\_\_

Reason for your visit (briefly): \_\_\_\_\_

**PAST MEDICAL HISTORY: Check if YOU have ever been diagnosed with:**

- |                         |   |                          |   |
|-------------------------|---|--------------------------|---|
| Arthritis               | <input type="checkbox"/> YR diagnosed _____ | Liver Disease            | <input type="checkbox"/> YR diagnosed _____     |
| Asthma                  | <input type="checkbox"/> YR diagnosed _____ | Thyroid Disease          | <input type="checkbox"/> YR diagnosed _____     |
| Diabetes                | <input type="checkbox"/> YR diagnosed _____ | Anemia                   | <input type="checkbox"/> YR diagnosed _____     |
| High Blood Pressure     | <input type="checkbox"/> YR diagnosed _____ | Lupus/Autoimmune Disease | <input type="checkbox"/> YR diagnosed _____     |
| Lung Disease            | <input type="checkbox"/> YR diagnosed _____ | Acid Reflux              | <input type="checkbox"/> YR diagnosed _____     |
| Anxiety/Depression      | <input type="checkbox"/> YR diagnosed _____ | Peptic Ulcer             | <input type="checkbox"/> YR diagnosed _____     |
| Heart Attack            | <input type="checkbox"/> YR diagnosed _____ | Hepatitis Type A, B, C   | <input type="checkbox"/> YR diagnosed _____     |
| Coronary Artery Disease | <input type="checkbox"/> YR diagnosed _____ | Hemorrhoids              | <input type="checkbox"/> YR diagnosed _____     |
| High Cholesterol        | <input type="checkbox"/> YR diagnosed _____ | HIV Infection            | <input type="checkbox"/> YR diagnosed _____     |
| Cancer (type)           | <input type="checkbox"/> YR diagnosed _____ | Blood Transfusion        | <input type="checkbox"/> Last Transfusion _____ |
| Stroke                  | <input type="checkbox"/> YR diagnosed _____ | Blood Clots              | <input type="checkbox"/> YR diagnosed _____     |
| Kidney Disease          | <input type="checkbox"/> YR diagnosed _____ | OTHER                    | _____   |

**SURGERIES:**

YEAR	DESCRIPTION OR TYPE	HOSPITAL

**MEDICATION ALLERGIES:**

ALLERGY	TYPE OF REACTION

**CURRENT MEDICATIONS: Please list CURRENT prescription medicines, over-the-counter medicines, herbal medicines. Please include DOSE in milligrams (MG) and how often you are taking them.**

NAME	MG	HOW OFTEN	NAME	MG	HOW OFTEN



# Patient Registration Form (Continued)

## IMMUNIZATIONS:

Last Flu shot: YR \_\_\_\_\_ Last Pneumonia shot: YR \_\_\_\_\_  
Have you ever been vaccinated for Shingles:  Yes  No When \_\_\_\_\_

## SOCIAL HISTORY:

Marital Status:  Married  Separated  Divorced  Widowed  Single  
You live with: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
Occupation: (past or present) \_\_\_\_\_ Presently working:  Yes  No  
Have you ever used tobacco:  Yes  No How many packs per day \_\_\_\_\_  
How long have you smoked \_\_\_\_\_ If you quit, how long ago \_\_\_\_\_  
Do you consume alcohol:  Yes  No If yes, what type/amount \_\_\_\_\_ How often \_\_\_\_\_  
Do you use drugs recreationally:  Yes  No

## FAMILY HISTORY: BRIEFLY list major health problems as well as cancer

Father \_\_\_\_\_ Mother \_\_\_\_\_  
Brothers \_\_\_\_\_ Sisters \_\_\_\_\_  
Children \_\_\_\_\_

## REVIEW OF SYSTEMS: Check ANY of the symptoms you are having:

Constitutional:  Fever  Weight loss  Fatigue  Loss of appetite  Night sweats  Chills  
Eyes:  Change in vision  Redness  Pain  Blurred vision  Difficulty seeing  
Ear/Nose/Throat:  Sore throat  Hoarseness  Pain  Difficulty swallowing  nose bleeds  
 hearing loss  ringing in ears  
Cardiac:  Chest pain  Palpitations  Dizziness  Lightheadedness  Ankle swelling  
Respiratory:  Shortness of breath  Cough  Blood in sputum  
Gastrointestinal:  Nausea  Vomiting  Heartburn  Diarrhea  Abdominal pain  Rectal bleeding  
 Bowel incontinence  Blood in stool  Constipation  
Musculoskeletal:  Joint pain  Back pain  
Skin:  Rashes  Itching  Yellow skin  
Urologic:  Frequency  Urgency  Pain with urination  Blood in urine  Urine leakage  
Blood/Lymph System:  Bruising  Bleeding (anywhere)  Lumps in armpits  lumps in neck  Lumps in groin  
Neurological:  Weakness of arms or legs  Headaches  Seizure  Fainting spells  Dizziness  Numbness  
 Difficulty walking  Difficulty thinking clearly  
Psychiatric:  Nervousness  Anxiety  Depression  Difficulty sleeping  
Last Colonoscopy: YR \_\_\_\_\_  
Last Mammogram: Month \_\_\_\_\_ YR \_\_\_\_\_  
Last Pap Smear: YR \_\_\_\_\_

## PAIN SCALE: please rate your pain from 0 to 10 0 = No pain 10 = Very severe

"I rate my pain as number \_\_\_\_\_"  
Location of pain: \_\_\_\_\_

## FOR BREAST CANCER/OVARIAN CANCER PATIENTS ONLY:

Age of first menstrual cycle: \_\_\_\_\_ Year of last menstrual cycle: \_\_\_\_\_  
How old were you when your first child was born: \_\_\_\_\_ Did you breast feed your children?  Yes  No  
Did you use hormone replacement therapy:  Yes  No  
Year of last bone density \_\_\_\_\_