



PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Name _____

Date of Birth _____

Address _____

Social Security # _____

City, State, Zip _____

Marital Status: Married Single Divorced Widowed

Phone _____ Type _____

Sex: Male Female

Phone _____ Type _____

Employment Status: Employed Unemployed Retired

Email address _____

Employer: _____

PRIMARY INSURANCE:

Carrier _____

SECONDARY INSURANCE:

Carrier _____

Insured ID# _____

Insured ID# _____

Policy Group _____

Policy Group _____

Insured Name _____

Insured Name _____

Date of Birth _____ SS# _____

Date of Birth _____ SS# _____

Relationship to Patient _____

Relationship to Patient _____

Insured Employer _____

Insured Employer _____

RESPONSIBLE PARTY: CHECK IF SAME AS PATIENT

Name _____

Date of Birth _____

Address _____

Social Security # _____

City, State, Zip _____

Employer _____

Phone _____ Type _____

Phone _____

REFERRED BY:

- Physician: _____
- Other Patient/Friend
- Insurance
- Newspaper Ad
- Yellow Page Ad
- Website



PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to complete this form in its entirety.

Patient Full Name _____ Date of Birth _____ Appt Date _____

Pharmacy Preference (include location) _____

Referred By _____ Name of Primary Care (Family) Physician _____

What is the main reason we are seeing you today?

CURRENT MEDICATIONS:

Are you taking ANY medication now? (This includes prescription, over-the-counter or herbal medications)

No Yes If yes, please list below.

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS?

No Yes If yes, please list below.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Check any of the following that you are allergic to:

- Animal Exposure Dust Pollen Moldy Places Iodine
- Perfume Latex Ant Stings Bee Stings Fly/Flying Insects
- Other: _____

Have you ever had an allergy skin test? No Yes

Have you ever had an allergy blood test? No Yes

PAST HEALTH HISTORY: Place a check in the box next to any condition for which you have been previously diagnosed.

Cancer:

- Breast Cancer Yes What year? _____
- Lung Cancer Yes What year? _____
- Prostate Cancer Yes What year? _____
- Skin Cancer Yes What year? _____
- Throat Cancer Yes What year? _____
- Other Cancer Yes What type/year? _____

Head & Face:

Migraine Headache Yes What year? _____

Eyes:

- Cataracts Yes What year? _____
- Glaucoma Yes What year? _____

Nose and Sinus:

Nasal Allergies Yes What year? _____

Mouth and Throat:
 Sleep Apnea Yes What year? _____

Heart and Blood Vessels:
 Deep Vein Thrombosis Yes What year? _____
 High/Elevated Cholesterol Yes What year? _____
 High Blood pressure Yes What year? _____
 Heart Attack Yes What year? _____

Lungs and Respiratory:
 Asthma Yes What year? _____
 Chronic Bronchitis Yes What year? _____
 Emphysema Yes What year? _____
 Hemophilia Yes What year? _____
 Tuberculosis Yes What year? _____

Stomach and Digestive:
 Gastroesophageal Reflux Yes What year? _____
 Hepatitis Yes What year? _____
 Stomach ulcer Yes What year? _____

Kidney and Gender Problems:

Renal failure Yes What year? _____
 Enlarged Prostate Yes What year? _____
 Are you pregnant? Yes What year? _____

Brain:
 Stroke Yes What year? _____

Mental & Emotional:
 Depression Yes What year? _____
 Chronic Anxiety Yes What year? _____

Glands, Hormones, and Sugar Control:
 Diabetes Yes What year? _____
 Thyroid dysfunction Yes What year? _____

Blood & Lymph Node problems:
 Anemia Yes What year? _____

Allergies, Immune & Infectious Problems:
 HIV Yes What year? _____
 Infectious mononucleosis Yes What year? _____

Other Medical Issues:

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? No Yes
 If yes, please list what sort of problems. _____

Have you ever had ear, nose or throat surgery? No Yes
 If yes, list any surgeries and when they were done. _____

Have you ever had any other type of surgery? No Yes
 If yes, list any surgeries and when they were done. _____

Have you been hospitalized for a medical problem before? No Yes
 If yes, list hospitalizations, the reason for admission and the date. _____

SERIOUS INJURIES:

Have you had any Head, Facial, or Ear injuries: No Yes If yes, when: _____ What Type: _____

IMMUNIZATIONS:

Are your immunizations up to date? No Yes

FOR CHILDREN (UNDER AGE 15) please complete the following:

Do they attend day care? No Yes
 Was patient's mother's pregnancy normal? No Yes Not Sure
 Did patient pass their newborn screening? No Yes Not Sure

FAMILY HISTORY: Check the corresponding box if the family member has had any of the following:

Anesthesia Problem	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Lung Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Thyroid Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Hearing Loss after age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Hearing Loss before age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Bleeding/Clotting Problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nasal Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

SOCIAL HISTORY:

What is or was your occupation? _____ Check here if you are retired

Have you ever used tobacco in any form? No Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type)		

Do you consume alcohol? No Yes

If yes, please complete the following:

Type of Alcohol	How Much	How often

Are you exposed to second hand smoke? No Yes

Do you use drugs recreationally? No Yes If yes, please list _____

Describe your caffeine usage:

none

about 1 caffeinated drink per day

about 2 to 3 caffeinated drinks per day

4 or more caffeinated drinks per day

other amount: _____

Home Living Situation (mark all that apply)

Alone Spouse Children Mother Father In Assisted Living Nursing Home Other

REVIEW OF SYSTEMS: Mark yes or no and CHECK any of the following you have recently had.

General health problems No Yes fever sleeping problems unintentional weight loss fatigue (excessive)

Eye problems No Yes - painful eye itchy eyes blurred vision loss of vision

Ear problems No Yes - ear pain ear drainage hearing loss dizziness ringing

Nose & Sinus problems No Yes - nasal congestion frequent nosebleeds post nasal drainage

Mouth & Throat problems No Yes - hoarseness or other voice changes partials or dentures
 belching sour material into throat fever blisters or cold sores Snoring

Heart or circulation problems No Yes - blacking out or fainting chest pain heart murmur
 irregular heartbeat leg cramps swelling of ankles

Lung or respiratory problems No Yes - freq non-productive cough freq productive cough shortness of breath
 coughing up blood wheezing

Genitourinary problems No Yes - bed wetting urinating more than usual

Stomach problems No Yes - abdominal pain diarrhea heartburn nausea vomiting
 painful swallowing

Bone, joint, or muscle problems No Yes - pain in neck painful joints stiffness in joints swelling of joints

Skin problems No Yes - moles that have changed poor healing wound skin blisters or lesions

Brain or Nervous system problems No Yes - numbness seizures change in sense of smell change in sense of taste
 drooping of one side of face headache severe face pain
 tremor

Problems with Glands, Hormones No Yes - feel hot when others do not increased appetite cold feeling
 thirst increased unintentional weight gain

Problems with Blood or Lymph nodes No Yes - bleeds excessively after injury bruises easily lumps in neck

Problems with Allergies No Yes - food intolerances freq sneezing hives severe reaction to insect bite