PATIENT REGISTRATION

PATIENT ID #___________ CELL PHONE ___________________________

DATE __________________ HOME PHONE _________________________

PATIENT____ **DOB** ________________ AGE ______ SEX M / F
(Last Name) (First Name) (Initial)

ADDRESS: ____CITY______________________________ STATE ______ ZIP CODE____________

EMAIL ADDRESS ____ PATIENTS SS# ________-______-_________

WHO REFERRED YOU TO OUR OFFICE? Patient / Doctor Who? _________________________________ _____ Google search _____ Our website

Primary Care Physician ________________________________ MD / DO ADDRESS ________________________________ Ph ______________________

IN CASE OF EMERGENCY

WHO SHOULD BE NOTIFIED? _____________________________________ RELATIONSHIP TO PATIENT_________________ Phone (H) ________________

LOCAL/MAIL-ORDER PHARMACY INFO

PHARMACY_____________________________ ADDRESS (cross streets)_____________________________Phone (_______) ______________________

Medco /Express Scripts _____ Caremark ____ Pharmacy Advantage _____ Diplomat _____ Walgreens Specialty _____ Novitis _____

ETHNICITY: ______________________________ **RACE** ______________________________

SOCIAL HISTORY

Marital Status ___ Single ___ Married ___Divorced ___Widowed

Alcohol Intake ___ None ___ Rarely ___ Moderate ___ Heavy

Smoking status ___ Never Smoker ____ Current smoker ___ Former Smoker How long ago? ___ yrs smoked

If a current smoker, smoker for how long? _____ mos. ___Yrs.

Smoking ___1/4 PPday ___1/2 PP day ___ 1 PPD ___ 2PPD ___1 Pk per wk

chewing Tobacco: ___1/day ___ 2-5 /day ___(5+days)

Illicit Drugs ___Yes ___ No If yes, what _______________________________________

Caffeine intake ___None ___Occasional ___Moderate ___Heavy

Exercise level ___None ___Light (1-2day wk) ___Moderate(3-4days wk) ___Heavy(5+day)

Occupation ____ retired Y / N

Children Y / N If yes, how many children ? (and yr born)____

____

Left handed / Right handed

PLEASE CHECK ANY CURRENT OR MEDICAL HISTORY:

Alzheimer's ____ Aneurysm ____ Anxiety ____ Arthritis ____ Asthma ____ Autoimmune ____Back Problems ____
Brain Tumor ____Cancer____ COPD ____ Dementia ____ Depression ____ Diabetes ____ Fibromyalgia ____
Gout____ Headaches/Migraines ____ Head Trauma ____ Heart problems ____ Hepatitis ____ HIV/AIDS ____
Hypertension____ High Cholesterol ____ Kidney disease ____ Liver disease ___ MRSA ___ Meniere's/Vertigo____
Meningitis ____ MS ____ Neck pain ____ Osteoporosis ____ PTSD ____ Parkinson's disease ___Pneumonia____
Thyroid ____ TB ____ Seizures ____ Sleep problems____ Sleep Apnea___ Stroke/ TIA ____ Ulcer____ Vision Problems
____ Other: ____

SURGERY	year done	SURGERY	year done

MEDICATION	STRENGTH	DOSE	MEDICATION	STRENGTH	DOSE

MEDICATION ALLERGY

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

FAMILY HISTORY ____Not applicable -Adopted

	MEDICAL PROBLEMS/CONDITIONS	year diagnosed	death Y / N	AGE	IF YES, WHAT YEAR
MOTHER:			Y / N		
FATHER:			Y / N		
BROTHER:			Y / N		
BROTHER:			Y / N		
SISTER:			Y / N		
SISTER:			Y / N		
MATERNAL GRD MOTHER			Y / N		
MATERNAL GRD FATHER			Y / N		
PATERNAL GRD MOTHER			Y / N		
PATERNAL GRD FATHER			Y / N		