



PATIENT REGISTRATION

FIRST NAME (LEGAL)				PREFERRED FIRST NAME		MI		LAST NAME	
MAILING ADDRESS				CITY				ZIP CODE	
HOME PHONE			CELL PHONE			CELL PHONE CARRIER			
WORK PHONE			EMAIL ADDRESS						
DATE OF BIRTH			RELATIONSHIP STATUS (please circle one) NEVER MARRIED MARRIED DIVORCED SEPARATED WIDOWED DOMESTIC PARTNER OTHER _____						
RACE (please circle one) WHITE BLACK AMERICAN INDIAN ASIAN OTHER _____		ETHNICITY (please circle one) HISPANIC ORIGIN NOT OF HISPANIC ORIGIN OTHER _____		LANGUAGE PREFERENCE (please circle one) ENGLISH OTHER _____			GENDER _____		
PHARMACY				PRIMARY DOCTOR					
EMERGENCY CONTACT NAME					EMERGENCY CONTACT PHONE NUMBER				
PRIMARY INSURANCE INFORMATION									
PRIMARY INSURANCE COMPANY NAME									
INSURANCE COMPANY ADDRESS									
NAME OF INSURANCE POLICY HOLDER						INSURED'S DATE OF BIRTH			
INSURANCE GROUP #			INSURED'S POLICY #			PATIENT INSURANCE POLICY #			
RELATIONSHIP TO INSURED			EFFECTIVE DATE OF INSURANCE PLAN			IF AUTO OR WORK RELATED, DATE OF INJURY			
SECONDARY INSURANCE INFORMATION									
SECONDARY INSURANCE COMPANY NAME									
INSURANCE COMPANY ADDRESS									
NAME OF INSURANCE POLICY HOLDER						INSURED'S DATE OF BIRTH			
INSURANCE GROUP #			INSURED'S POLICY #			PATIENT INSURANCE POLICY #			
RELATIONSHIP TO INSURED			EFFECTIVE DATE OF INSURANCE PLAN			IF AUTO OR WORK RELATED, DATE OF INJURY			

Patient Name: _____

PLEASE LIST ANY CHILDHOOD ILLNESSES

<input type="checkbox"/>	Chickenpox
<input type="checkbox"/>	Chickenpox - Vaccine
<input type="checkbox"/>	Other:

<input type="checkbox"/>	Measles
<input type="checkbox"/>	Mumps
<input type="checkbox"/>	

<input type="checkbox"/>	Rubella
<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	

PLEASE CHECK ALL MEDICAL PROBLEMS YOU HAVE OR HAVE HAD:

Please check box to **LEFT** of illness or problem.

<input type="checkbox"/>	Abdominal Aortic Aneurysm
<input type="checkbox"/>	Ashkenazi Jewish
<input type="checkbox"/>	Acne
<input type="checkbox"/>	ADHD
<input type="checkbox"/>	AIDS
<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	Alzheimer's Disease
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Angina
<input type="checkbox"/>	Arteriosclerosis
<input type="checkbox"/>	Arthritis, Rheumatoid
<input type="checkbox"/>	Arthritis, Osteo
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Atrial Fibrillation
<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	Blood Transfusions
<input type="checkbox"/>	Cancer* (List below.)
<input type="checkbox"/>	Carotid Artery Stenosis
<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	Cerebrovascular Accident (CVA)
<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	CNS Tumors
<input type="checkbox"/>	Colitis
<input type="checkbox"/>	Colon Polyps
<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	COPD
<input type="checkbox"/>	Coronary Artery Disease
<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Dermatitis
<input type="checkbox"/>	Diabetes- Insulin Dependent
<input type="checkbox"/>	Diabetes- Non-Insulin Dependent
<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	Diverticulosis
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

<input type="checkbox"/>	Drug Addiction
<input type="checkbox"/>	Eating Disorder
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Esophagitis
<input type="checkbox"/>	Fibrocystic Disease of Breast
<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	GERD
<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	Gout
<input type="checkbox"/>	Hard of Hearing
<input type="checkbox"/>	Heart Attack (MI)
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Heart Failure
<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	Herpes
<input type="checkbox"/>	Hiatal Hernia
<input type="checkbox"/>	HIV
<input type="checkbox"/>	Hodgkin's Disease
<input type="checkbox"/>	Hypercholesterolemia
<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	Infertility
<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	
<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Migraine with aura
<input type="checkbox"/>	Migraine without aura
<input type="checkbox"/>	Mitral Valve Prolapse (MVP)
<input type="checkbox"/>	Multiple Sclerosis (MS)
<input type="checkbox"/>	Obesity
<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Peptic Ulcer Disease
<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Peripheral Vascular Disease
<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Poliomyelitis
<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Pulmonary Embolism
<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	Transient Ischemic Attack (TIA)
<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Hypothyroidism
<input type="checkbox"/>	Hyperthyroidism
<input type="checkbox"/>	Grave's Disease
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Tumors
<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Venous Insufficiency
<input type="checkbox"/>	
<input type="checkbox"/>	Vertigo
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

***PLEASE LIST ANY CANCER HISTORY**

DATE	TYPE OF CANCER	THERAPY

Patient Name: _____

SURGERIES AND PROCEDURES

DATE	TYPE OF SURGERY	SURGEON	HOSPITAL	COMPLICATIONS

HOSPITALIZATIONS (Please list all with dates.)

DATE	TYPE OF HOSPITALIZATION	PHYSICIAN	HOSPITAL	COMPLICATIONS

ASSISTIVE DEVICES (List any assistive devices you wear or use, i.e. hearing aids, contact lenses, glasses, walkers.)

FAMILY MEDICAL HISTORY

CANCER TYPE	RELATIONSHIP	AGE AT DIAGNOSIS	LIVING (Yes /No) If no, age deceased
<input type="checkbox"/> Breast cancer			
<input type="checkbox"/> Ovarian cancer			
<input type="checkbox"/> Endometrial cancer			
<input type="checkbox"/> Colon cancer			
<input type="checkbox"/> Pancreatic cancer			

(Please list all family illnesses.)

RELATIVE	ILLNESSES & AGE AT DIAGNOSIS	LIVING (Yes /No) If no, age deceased
Father		
Mother		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Brothers # _____		
Sisters # _____		
Other (Children, Aunts, Uncles, Nieces, Nephews, Cousins)		

Patient Name: _____

SOCIAL/PERSONAL HISTORY

Highest level of education attained: _____	Marital Status: _____
Occupation: _____	Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____	

Has anyone ever hurt you in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	

Do you smoke? (Cigarettes or E-Cigarettes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, # cigarettes per day:
If yes, how important is it for you to quit smoking?		(Circle one) 1 2 3 4 5 6 7 8 9 10
If yes, how ready are you to quit smoking?		(Circle one) 1 2 3 4 5 6 7 8 9 10
If no, did you previously smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, # cigarettes per day:
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, # drinks per day:
Do you drink caffeine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type and # cups per day:
Do you use Marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often:
Do you use drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type and how often:
Do you exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type and how often:

Are you currently sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is intercourse painful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total # of sexual partners in lifetime:	Is your sexual partner <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		
Do you have any history of sexually transmitted diseases (STD'S)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes describe:	
What is your gender identity?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other: _____		
Sexual Orientation:	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Gay/Lesbian/Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other (please specify): _____		

Are there any issues you would like to discuss today?

Thank you for trusting us with your care