

PATIENT REGISTRATION

Name _____
 Address _____ Occupation _____
 Phone (home) _____ (work) _____ Date of birth _____ Age _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: _____
 Present medications: _____
 Allergies to medications: _____
 Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____
 Other physicians currently treating you: _____
 Previous or other medical problems: _____
 List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____
 Females only: Are you pregnant, planning a pregnancy or nursing a child? Yes No

MEDICAL HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Dizziness / Fainting _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Hyperlipidemia _____ | <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> GI Disorder _____ |
| <input type="checkbox"/> Heart palpitations _____ | <input type="checkbox"/> Fatigue _____ | <input type="checkbox"/> Sexual dysfunction _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Menstrual dysfunction _____ |
| <input type="checkbox"/> Arrhythmia _____ | <input type="checkbox"/> Orthopnea _____ | <input type="checkbox"/> Incontinence _____ |
| <input type="checkbox"/> Chest pain / Angina _____ | <input type="checkbox"/> Allergies / Hay fever _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> MI _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Stroke / TIAs _____ | <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Claudication _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Congestive heart failure _____ | <input type="checkbox"/> Venereal disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Congenital heart Disease _____ | <input type="checkbox"/> Scarlet fever _____ | <input type="checkbox"/> Endocrine disease _____ |
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Liver disease _____ | <input type="checkbox"/> Other _____ |

HABITS

- | | | |
|---|---|---|
| <input type="checkbox"/> Smoke: Packs daily _____
How long? _____
Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups daily _____
Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____ |
| <input type="checkbox"/> Exercise routine: _____ | <input type="checkbox"/> Alcohol: Type _____
Amount _____ | |
| | <input type="checkbox"/> Diet: Salt intake _____
Fat intake _____ | |

Hepatitis C risk factor: Blood transfusion prior to 1992 IV drug use (1+ times) Contact with blood/bodily fluid
 Tattoos Body piercing

IMMUNIZATIONS

(Year last received, if known)

Smallpox _____
 Tetanus _____
 Typhoid _____
 Polio _____
 Influenza _____
 Pneumonia _____
 Rubella _____
 Hepatitis _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name