Registration

Today's Date ____/____/________

Last Name: __________________________ **First** Name: __________________________ Middle Initial: ___

Birthdate: ___ /___ /______ SSN: ______ - ____ - ________

Primary Phone: (______) ______ - ________ Secondary Phone: (______) ______ - ________

Email: _____________________________________ @ _______________________________

How do you learn best? ☐ Seeing ☐ Hearing ☐ Doing ☐ Pictures/Videos

Name & Relationship of person completing this form (if not patient): ________________________________

Emergency Contact Info	Name: ____ Relation: ____ Phone: (______) ______ - ________

This is a confidential record and will be kept in your patient record. Information collected here will not be released to anyone without your authorization

Health History and Screening

Today's Date ____/____/________

How would you rate your current overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please explain your rating (optional): ____
____

Personal Health History: *[Do you have now or have you had any of the following?]*

Musculoskeletal
- ☐ Arthritis
- ☐ Fracture(s)
- ☐ Gout
- ☐ Osteoporosis

Neurologic
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Seizures

Gastrointestinal
- ☐ Chron's Disease
- ☐ Irritable Bowel
- ☐ Ulcers

Cardiopulmonary
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Pacemaker/Defibrillator
- ☐ Lung disease
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Clotting Disorder
- ☐ High Blood Pressure
- ☐ Low Blood Pressure

Endocrine
- ☐ Diabetes
- ☐ Thyroid dysfunction

Urogynecologic
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Pelvic Pain
- ☐ Prostate Disease
- ☐ STD(s)

Mental Health
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Other Mental Health

Other
- ☐ Allergies
- ☐ Autoimmune Condition
- ☐ Cancer
- ☐ Eye Condition
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Sleep Apnea
- ☐ Sleep Apnea

Details (regarding above): ____
____
____

Additional Health History: ____
____
____

Surgical History: *[Please list any **previous surgeries** you have had **and** approximate **date** (if known)]*

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

# of Visits to ER in past 12 months: ☐ 0 ☐ 1-2 ☐ 3+

# of Overnight hospital stays in past 12 months: ☐ 0 ☐ 1-2 ☐ 3+

Do you Live Alone? ☐ Yes ☐ No

Tobacco, Alcohol, & Drug Use *[check the boxes that apply to you]*

Smoking: ☐ Never ☐ Currently ____ packs/day ☐ Previously *(Last use: _______)* ____ packs/day ☐ Declined to Answer

Tobacco: ☐ Never ☐ Currently ☐ Previously *(Last use: _______)* ☐ Declined to Answer

Alcohol: ☐ Never ☐ Currently ☐ Previously *(Last use: _______)* ☐ Declined to Answer
Frequency: ☐ Occasionally ☐ Daily ☐ Binge
Avg # of Drinks: _______ *(1 drink = 12 oz beer, glass of wine, 1 shot or cocktail)*

Drugs: ☐ Never ☐ Currently ☐ Previously *(Last use: _______)* ☐ Declined to Answer
☐ Marijuana ☐ Narcotics ☐ Meth ☐ IV Drugs ☐ Other ___________

Immunization/Vaccination History:

Shingles: ☐ Yes, year _______ ☐ No ☐ Unsure

Flu: ☐ Yes, year _______ ☐ No ☐ Unsure

Covid-19: ☐ Yes, year _______ ☐ No ☐ Unsure

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Health History and Screening

Today's Date ____/____/________

Family Health History:

Father: ☐ Living ☐ Deceased

Mother: ☐ Living ☐ Deceased

Sibling(s): ☐ Living ☐ Deceased

☐ Family History Unknown

Check the appropriate box if a blood relative has had any of the following:

Alcohol Abuse	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	Blood Clot	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Substance Abuse	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Dementia	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	Osteoporosis	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	Thyroid Disease	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	Rheumatoid Arthritis	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Heart attack prior to 55	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	Lupus	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent

Other medical information of which you would like to inform your provider today:

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