# PATIENT REGISTRATION AND MEDICAL HISTORY

Date_________________________ (*PLEASE PRINT*) Home Phone (_____)_____________________

Email Address _______________________________ Cell Phone (_____)______________________

Patient_________________________ _________________________ ___________________________ ________________
Last Name First Name Middle Initial Preferred Name

Street Address______________________________ City____________________ State ____________ Zip _______________

Sex [ ] Male [ ]Female Age____________ Birthdate ___________ [ ] Married [ ] Widowed [ ]Single [ ] Minor
[ ] Separated [ ] Divorced [ ] Partnered_____yrs

Social Security #____________________________________ Occupation______________________________________

Employer/School____________________________________ Employer/School phone#_(_____)____________________
Student [ ] full time [ ] part-time

Spouse/Parent birthdate_____________________________

Spouse/Parent Name_________________________________

Spouse/Parent SS# _________________________________

Spouse/Parent Employer______________________________

Spouse Occupation__________________________________ Who is responsible for the account?_____________________

Business Phone#_(_____)___________________________ Relationship to patient______________________________

In case of emergency, who should be notified?_____________ Emergency Phone# _(_____)________________________
___________________________________________________

Referred by _______________________________________

## MEDICAL HISTORY

Physician's Name______________________________________ Date of Last Physical_____________________________

Have you ever had any of the following? (check boxes that apply):

[ ] Allergies Seasonal
[ ] Allergies (medical)
[ ] Arthritis
[ ] Artificial Heart Valves/Joints/Screws etc.
[ ] Back Problems
[ ] Bleeding Abnormally
[ ] Blood Disease
[ ] Cancer (type?) ____________________
[ ] Chemical Dependency
[ ] Chronic Diarrhea
[ ] Circulatory Problems
[ ] Congenital Heart Lesions
[ ] Diabetes

[ ] Epilepsy
[ ] Headaches
[ ] Heart Murmur
[ ] Heart Problems
[ ] Hemophilia
[ ] Hepatitis A,B,C, Jaundice or Liver Disease
[ ] Hernia Repair
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Low Blood Pressure
[ ] Mitral Valve Prolapse
[ ] Nervous Problems
[ ] Pacemaker

[ ] Psychiatric Care
[ ] Radiation Treatment
[ ] Recent Weight Loss
[ ] Respiratory Disease
[ ] Rheumatic Fever
[ ] Sinus Problems
[ ] Special Diet
[ ] Stroke
[ ] Swollen Neck Gland
[ ] Tuberculosis
active? Y / N
____________________
[ ] Ulcer

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? [ ]Y [ ] N
If so, please list the medications etc. ____________________________________________________________
Are you taking any medication at this time? [ ] Y [ ] N If so, what kind? ______________________________
Are you under the care of a physician? [ ] Y [ ] N For what conditions?__________________________________

(Women) Do you suspect that you are pregnant? [ ] Y [ ] N Due Date _____________ Nursing? [ ] Y [ ] N

Is there anything else we should know about your medical history?____________________________________