PATIENT REGISTRATION FORM

Today's Date:	

PERSONAL INFORMATION

First name:	Last name:	Middle:
Is this your legal name? Y N	If not, what is your legal name?	

Marital status:	Birth date:	Age:	Sex:
Occupation:	Employer:		
Street address:		P.O. Box:	
City:	State:	ZIP Code:	
Home phone:	Work phone:		
Cell phone:	Email address:		
Emergency Contact:			
Is there anyone we can thank for referring you?			
Other family members seen here:			

MEDICATION & SUPPLEMENT INFORMATION

Please list all of the medications and supplements you are currently taking. If needed, please continue your list on a separate sheet.

Medication or Supplement name	Dosage

FAMILY HISTORY

If any blood relatives have suffered from the following, please indicate which relative.

Allergies	Asthma	Anemia	Arthritis	Cancer
Alcoholism	Diabetes	Epilepsy	Headaches	Stroke
Kidney/Bladder Disorders	Mental Illness	Ulcers		
Heart Disease	Blood Clotting Disorders			
High Blood Pressure	Other			

HOSPITALIZATIONS

Year	Operation or Illness	Name of Hospital	City and State

MEDICAL HISTORY

Please indicate past and present conditions.

☐ Failing Vision	☐ Hemorrhoids	☐ Scarlet Fever
☐ Double or blurred vision	☐ Gall Bladder Trouble	☐ Rheumatic Fever
☐ Eye Pain	☐ Hernia	☐ Alcoholism
☐ Decreased Hearing		☐ Alcohol_____amt/day
☐ Ringing/buzzing in ears	☐ Chronic Fatigue	☐ Cigarettes_____amt/day
☐ Ear Infections	☐ Recent Weight Loss	☐ Coffee/Tea_____cups/day
☐ Allergies/Hay Fever	☐ Excessive Weight Gain	
☐ Sinus Trouble	☐ Thyroid Disease	☐ Anemia
☐ Nose Bleeds	☐ Cancer	☐ Malaria
☐ Frequent Sore Throats	☐ Diabetes	☐ Bruise Easily
☐ Prolonged Hoarseness		☐ Mononucleosis
	☐ Convulsions/Seizure	
☐ Asthma	☐ Stroke	☐ Bladder Infections
☐ Emphysema	☐ Tremors	☐ Kidney Infections
☐ Chronic Cough	☐ Muscle Weakness	☐ Pain or Urination
☐ Bronchitis	☐ Numbness/Tingling Sensation	☐ Poor control of Urination
☐ Pneumonia	☐ Frequent Headaches	☐ Decreased force of Urination
☐ Tuberculosis		☐ Blood in Urine
☐ Shortness of Breath on Exertion	☐ Arthritis	☐ Kidney Stones
☐ Shortness of Breath Lying Flat	☐ Gout	☐ Sexually Transmitted Disease
☐ Chest Pains	☐ Cold or Numb Feet	
☐ Heart Murmurs		**Female Only:**
☐ Palpitations	☐ Rashes	Number of Pregnancies:
☐ Swollen Ankles	☐ Psoriasis	Number of Live Births:
☐ Fainting Spells	☐ Eczema	Number of Miscarriages:
☐ Leg pain when walking	☐ Hives	Method of Birth Control:
☐ Varicose Veins/Phlebitis		Age of onset of menses:
	☐ Difficulty Sleeping	☐ Period Not Regular
☐ Recent Loss of Appetite	☐ Nervousness	☐ Light Flow
☐ Difficulty Swallowing	☐ Anxiety	☐ Moderate Flow
☐ Heartburn	☐ Depression	☐ Heavy Flow
☐ Persistent Nausea/Vomiting	☐ Memory Loss	Length of Flow:
☐ Ulcers	☐ Moodiness	Length of Cycle:
☐ Chronic Abdominal Pain	☐ Phobias	☐ Pain/bleeding with intercourse
☐ Recent Change in Bowel Habits	☐ Mumps	☐ PMS (medium to severe)
☐ Diarrhea	☐ Measles	☐ Other:
☐ Constipation	☐ German Measles	
☐ Black or Tarry Stools	☐ Chicken Pox	
☐ Red blood in stools	☐ Polio	

OTHER MEDICAL TREATMENT

PHYSICIAN'S NAME	ILLNESSES	TREATMENT