DATE:

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

First Name **Last Name** **Middle**

Is this your Legal Name? Yes No 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

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

OTHER MEDICAL TREATMENT

Physician's Name	Illness	Treatment