

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.

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

OTHER MEDICAL TREATMENT

PHYSICIAN'S NAME	ILLNESSES	TREATMENT