PATIENT REGISTRATION / MEDICAL HISTORY FORM

Patient (Legal) Name: _____ Today's Date_____

Preferred Name: _____Previous/Maiden Name: _____

Social Security #: _____Birth Date: _____ M ☐ F ☐

Mailing Address (City, State, Zip): _____

Phone number: Primary _____ Secondary: _____ Name of General Physician: _____

Patient's Employer: _____Occupation_____ Hobbies: _____

Spouse Name: _____Phone: _____SS#_____

Spouse Birth Date: _____ Spouse Employer: _____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18

Mother's Name: _____ Father's Name: _____

Mother's SS# : _____ Father's SS#: _____

Address (If Different Than Above): _____

Mother's DOB:_____Employer: _____Work Phone: _____

Father's DOB: _____Employer: _____Work Phone: _____

MEDICAL HISTORY

Are you pregnant or nursing? ☐ No ☐ Yes Height: _____ Weight: _____

Do you have any allergies to medications? ☐ No ☐ Yes If yes, please explain: _____

_____

List any medications you take, including over the counter: _____

_____

FAMILY HISTORY

Please note any family history (parent, grandparent, sibling, children). *Spouse diagnoses not needed.*

Disease/Condition	**NO**	**YES**	**Relationship to You**
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular degeneration	☐	☐	_____
Cataracts	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Cancer	☐	☐	_____

Please turn over to fill out side 2

Check any boxes that apply to you

Allergic / Immunologic
- ☐ none
- ☐ environmental allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ other

Cardiovascular
- ☐ none
- ☐ heart disease
- ☐ high blood pressure
- ☐ stroke
- ☐ vascular disease
- ☐ other

Constitutional
- ☐ none
- ☐ developmental disability
- ☐ weight loss
- ☐ fever
- ☐ fatigue
- ☐ trauma
- ☐ other

Ears, Nose, Mouth &Throat
- ☐ none
- ☐ upper resp. tract infection
- ☐ ringing- tinitus
- ☐ ear ache
- ☐ runny nose
- ☐ sore throat
- ☐ other

Smoking History (circle one)

Never smoked

Previous smoker

Current smoker

Endocrine
- ☐ none
- ☐ non-insulin dependent diab
- ☐ insulin dependent diabetes
- ☐ thyroid dysfunction
- ☐ hormonal dysfunction
- ☐ other

Eyes
- ☐ none
- ☐ glaucoma
- ☐ cataracts
- ☐ macular degeneration
- ☐ surgery
- ☐ inflammatory disorders
- ☐ double vision
- ☐ other

Gastrointestinal
- ☐ none
- ☐ crohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive
- ☐ other

Genitourinary
- ☐ none
- ☐ STD viral herpetic, chlamydia
- ☐ other

Hematologic / Lymphatic
- ☐ none
- ☐ anemia
- ☐ large volume blood loss
- ☐ leukemia
- ☐ other

Integumentary
- ☐ none
- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐ other

Musculoskeletal
- ☐ none
- ☐ fibromyalgia
- ☐ muscular dystrophy
- ☐ osteoarthritis
- ☐ ankylosing spondylitis
- ☐ other

Neurological
- ☐ none
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ cerebrovascular
- ☐ other

Psychiatric
- ☐ none
- ☐ depression
- ☐ panic disorder
- ☐ schizophrenia
- ☐ other

Respiratory
- ☐ none
- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐ other