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): _____

Primary/Cell Number: _____May we contact you via text message? ☐ Yes ☐ No Secondary Number: _____

Patient's Employer: _____Occupation_____ Hobbies: _____

COMPLETE THIS SECTION IF MARRIED

Spouse's Name: _____Phone: _____SS#_____

Spouse's Birth Date: _____ Spouse's 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:_____ Contact info: _____ Employer:_____

Father's DOB: _____ Contact info: _____Employer: _____

MEDICAL HISTORY

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

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

_____

Some pharmacies keep records in a common electronic file made available to prescribers. May we access this information to provide you more thorough care? ☐ **Yes** ☐ **No** List any medications you take, including over the counter, including your pharmacy. If you are not using a pharmacy or taking medications, please write in none in use or none taken:

Pharmacy:_____Medications:_____

_____

FAMILY HISTORY

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

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

Please Fill Out Both Sides

Check What Applies to You Personally. If none of these conditions apply, please check none.

Allergic / Immunologic
☐ none
☐ environmental allergy
☐ rheumatoid arthritis
☐ lupus
☐ other (Specify)

Cardiovascular
☐ none
☐ heart disease
☐ high blood pressure
☐ stroke
☐ vascular disease
☐ other (Specify)

Constitutional
☐ none
☐ developmental disability
☐ weight loss
☐ fever
☐ fatigue
☐ trauma
☐ other (Specify)

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

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

Eyes
☐ none
☐ glaucoma
☐ cataracts
☐ macular degeneration
☐ surgery (Specify)
☐ inflammatory disorders
☐ double vision
☐ other (Specify)

Gastrointestinal
☐ none
☐ crohn's
☐ colitis
☐ ulcer
☐ digestive
☐ other (Specify)

Genitourinary
☐ none
☐ STD viral herpetic, chlamydia
☐ other (Specify)

Hematologic / Lymphatic
☐ none
☐ anemia
☐ large volume blood loss
☐ leukemia
☐ other (Specify)

Integumentary
☐ none
☐ eczema
☐ rosacea
☐ psoriasis
☐ other (Specify)

Musculoskeletal
☐ none
☐ fibromyalgia
☐ muscular dystrophy
☐ osteoarthritis
☐ ankylosing spondylitis
☐ other (Specify)

Neurological
☐ none
☐ multiple sclerosis
☐ epilepsy
☐ Alzheimer's
☐ Parkinson's
☐ cerebrovascular
☐ other (Specify)

Psychiatric
☐ none
☐ depression
☐ panic disorder
☐ schizophrenia
☐ other (Specify)

Respiratory
☐ none
☐ asthma
☐ bronchitis
☐ emphysema
☐ other (Specify)

Cancer
☐ Yes ☐ No (If yes please specify)
Type:

Smoking

- ☐ Current Everyday
- ☐ Current Occasional
- ☐ Former Smoker
- ☐ Never Smoked
- ☐ Other Tobacco Products