PATIENT REGISTRATION *Please print*

Full Name: First MI Last		
DOB: / /	Gender: ☐ Male ☐ Female	
Address: Street Apt#		
City State Zip Code		
Primary Phone: ( ) -	Detailed Message? ☐ YES ☐ NO	
Secondary Phone: ( ) -	Detailed Message? ☐ YES ☐ NO	
Email Address:		
Would you like to sign up for the patient portal? ☐ YES ☐ NO		
Employer Name:		
Work Status: ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ NOT EMPLOYED ☐ STUDENT ☐ RETIRED		
Emergency Contact:	Relationship:	Primary Phone: ( ) -

Name of your Primary Care Doctor:	Name of your Referring Physician:

Race:		Preferred Language:	Ethnicity:
☐ American Indian or Alaska Native	☐ White	☐ English	☐ Hispanic or Latino
☐ Asian	☐ Multi-Racial	☐ Spanish	☐ Non-Hispanic or Latino
☐ Black or African American	☐ Pacific Islander	☐ Other	
☐ Native Hawaiian	☐ Declined		☐ Declined

Do you have Advanced Directives ☐ YES ☐ NO	Advanced Directives form given to patient ☐ YES ☐ NO

Is this a work related injury? ☐ YES ☐ NO	Claim #:	Date of injury:

Medicare Patients You are entitled to Medicare based on: AGE DISABILITY Renal ESRD

Are you employed? YES NO If NO - what year did you retire? _____

If married, is your spouse still working? YES NO If NO - what year did they retire? _____

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PATIENT EVALUATION AND HISTORY

Patient Full Name:_____DATE of visit:_____

CHIEF COMPLAINT: DESCRIBE THE PROBLEM FOR WHICH YOU ARE BEING SEEN TODAY:		
PLEASE LIST YOUR MEDICATIONS AND DOSAGE:		
PLEASE LIST ALL YOUR ALLERGIES, INCLUDING MEDICATIONS:		
		Are you allergic to LATEX? ☐ YES ☐ NO
LIST ANY HERBAL SUPPLEMENTS OR OVER-THE-COUNTER MEDICATIONS:		
LIST ANY PAST SURGERIES OR COLONOSCOPIES AND THE DATE OF OCCURRENCE:		
LIST ANY MAJOR MEDICAL CONDITIONS, ILLNESSES OR HOSPITALIZATIONS AND THE DATE OF OCCURRENCE:		

MEDICAL HISTORY

Do YOU have:		TYPE	Do Any FAMILY Members Have:	RELATION
CONVULSIONS	☐ YES ☐ NO		☐ YES ☐ NO	
ANESTHESIA ISSUES	☐ YES ☐ NO		☐ YES ☐ NO	
PRIOR TRANSFUSION	☐ YES ☐ NO		☐ YES ☐ NO	
HEART TROUBLE	☐ YES ☐ NO		☐ YES ☐ NO	
CANCER	☐ YES ☐ NO		☐ YES ☐ NO Breast Colon Ovarian	
LUNG PROBLEMS	☐ YES ☐ NO		☐ YES ☐ NO	
HEREDITARY DEFECT	☐ YES ☐ NO		☐ YES ☐ NO	
DIABETES	☐ YES ☐ NO		☐ YES ☐ NO	
GOUT	☐ YES ☐ NO		☐ YES ☐ NO	
ARTHRITIS	☐ YES ☐ NO		☐ YES ☐ NO	
BLEEDING PROBLEMS	☐ YES ☐ NO		☐ YES ☐ NO	
CHRONIC INFECTIONS	☐ YES ☐ NO		☐ YES ☐ NO	
THYROID DISEASE	☐ YES ☐ NO		☐ YES ☐ NO	

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VENEREAL DISEASE	☐ YES ☐ NO		☐ YES ☐ NO	
HISTORY OF STROKE	☐ YES ☐ NO		☐ YES ☐ NO	
LIVER PROBLEMS / HEPATITIS	☐ YES ☐ NO		☐ YES ☐ NO	
SLEEP APNEA / CPAP	☐ YES ☐ NO		☐ YES ☐ NO	
HIGH BLOOD PRESSURE	☐ YES ☐ NO		☐ YES ☐ NO	

SOCIAL HISTORY - DO YOU or HAVE YOU EVER…					
SMOKED	☐ YES ☐ NO	packs/day: Quit date:	Recreational Drug Use	☐ YES ☐ NO	type:
DRINK ALCOHOL	☐ YES ☐ NO	drinks/day:	Drink Caffeine	☐ YES ☐ NO	drinks/day:

HEIGHT_____ WEIGHT_____

☐ **Female:**	YES	NO
Do self breast exam	☐	☐
Irregular periods	☐	☐
Date of last menstural period:		
# Of Pregnancies:		

DO YOU CURRENTLY HAVE ANY OF THE FOLLWING IMPLANTS?	
Pacemaker	☐ YES ☐ NO
Breast	☐ YES ☐ NO
Cochlear	☐ YES ☐ NO
Port a Cath	☐ YES ☐ NO
Total Joint	☐ YES ☐ NO
Shunt	☐ YES ☐ NO
Brain Aneurysm Clip	☐ YES ☐ NO
ACID (automatic cardiac Internal defibrillator)	☐ YES ☐ NO

REVIEW OF SYSTEMS / SYMPTOMS

DO YOU HAVE or EVER HAD *in the last 3 months…*	**YES**	**NO**
☐ **CONSTITUTIONAL SYMPTOMS**		
Poor general health lately	☐	☐
Fever	☐	☐
Fatigue	☐	☐
☐ **EARS/NOSE/MOUTH/THROAT**		
Hearing loss	☐	☐
Ringing	☐	☐
Earaches	☐	☐
Drainage	☐	☐
Nose bleeds	☐	☐
Bleeding gums	☐	☐
Voice change	☐	☐
Sore throat	☐	☐
☐ **CARDIOVASCULAR**		
Leg swelling	☐	☐
Leg pain	☐	☐
Chest pain / Angina Pectoris	☐	☐
Palpatation	☐	☐
Shortness of breath lying down	☐	☐
Shortness of breath walking 1 block	☐	☐
Shortness of breath climbing flight of stairs	☐	☐

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☐ BREAST	YES	NO
Breast or Nipple Pain	☐	☐
Breast Mass	☐	☐
Breast swelling or change in size	☐	☐
Nipple discharge	☐	☐
Breast Skin Changes	☐	☐
☐ **RESPIRATORY**		
Chronic or frequent coughs	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
☐ **GASTROINTESTINAL**		
Loss of appetite	☐	☐
Change in bowel movements	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Frequent diarrhea	☐	☐
Painful bowel movements	☐	☐
Bright red rectal bleeding	☐	☐
Dark, tarry or maroon colored stools	☐	☐
Constipation	☐	☐
Abdominal pain	☐	☐
Anal incontinence or urgency	☐	☐
Heartburn	☐	☐
☐ **GENITOURNIARY**		
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Change in force of stream when urinating	☐	☐
☐ **ENDORCINE**		
Excessive urination	☐	☐
Excessive thirst	☐	☐
Cold intolerance	☐	☐
Heat intolerance	☐	☐

☐ MUSCULOSKELETAL	YES	NO
Joint pain	☐	☐
Joint swelling	☐	☐
Joint stiffness	☐	☐
Muscle weakness	☐	☐
☐ **SKIN**		
Change in skin color	☐	☐
Itching	☐	☐
Rash	☐	☐
Jaundice	☐	☐
Change in size of mole	☐	☐
☐ **NEUROLOGICAL**		
Frequent or recurring headaches	☐	☐
Dizziness	☐	☐
Convulsions or seizures	☐	☐
Paralysis	☐	☐
☐ **PSYCHIATRIC**		
Confusion	☐	☐
Memory loss	☐	☐
Depression	☐	☐
☐ **HEMATOLOGIC/LYMPHATIC**		
Bleeding tendency	☐	☐
Bruising tendency	☐	☐
☐ **EYES**		
Eye injury	☐	☐
Eye disease	☐	☐
Wear glasses/contact lenses	☐	☐
Blurred vision	☐	☐
Double vision	☐	☐
Glaucoma	☐	☐

Reviewed, and authenticated by:	**Date Reviewed:**
☐ Michael Towbin, MD ☐ Marion Johnson, MD ☐ Kelly Clinch, MD ☐ John Ebisu, MD ☐ Harry Kahn, MD ☐ Timo W. Hakkarainen, MD ☐ Analisa Armstrong, MD ☐ Katherine Batts, PA-C	

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