Michael Uzick, N.M.D.
1 W. Wetmore Rd., Suite 124
Tucson, AZ 85705
—
Telephone: (520) 887-4287
Fax: (520) 887-0100

PATIENT REGISTRATION

Name ____ Date of 1st visit: ____/____/_____

Address ____ Zip _______________

Birth date ____/____/_____ Age _____ Sex _____ **E-mail address** _________________________

Phone Numbers

Home:	**Cell:**	**Work:**

Employer ____ Occupation _______________________

Partner's Name ________________________________ Work phone __________________________

Contact in case of Emergency ____

If patient is a minor:

Mother's name ____

Employer ______________________________________ Wk Ph ________________________

Father's name ____

Employer _______________________________________ Wk Ph _______________________

How did you hear about us? ____

Please read and initial:
Cancellation policy – Cancellations must be made during regular business hours (Monday through Thursday). Monday appointments must be cancelled by closing on the previous Friday. All other appointment cancellations or no shows will be charged for the missed appointments.
Initial: ________

-Continued-

Patient History

Chief Complaints:

1. ____
2. ____
3. ____
4. ____

Other physicians or caring for you:

1. ____
2. ____
3. ____

Past Medical History: (Major illnesses, surgeries or injuries) Date

1. ____ __________
2. ____ __________
3. ____ __________
4. ____ __________

Current Prescription Medications:

	Drug name	Dosage	Taking since
1.			
2.			
3.			
4.			
5.			
6.			

Natural supplements: (vitamins, minerals, herbs, homeopathics etc.)

	Supplement name	Dosage	Taking since
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies: (medications, inhalants, foods, others)

1. ____
2. ____
3. ____
4. ____

- Date of last complete physical exam? _________________________________
- Tobacco use: Current _______ Past _______ How long? ________ Quit when? _______ How many cigarettes daily (on average) _______________
- Current occupation? ____
- Have you had any jobs that have involved exposure to chemicals/fumes/toxic metals? ____
- Do you have a water filter or buy filtered drinking water? __________________
- Family history of: Diabetes _______ Heart disease/stroke ________________ Cancer _______________ Arthritis ______________ Other______________
- Currently sexually active? ___________
- **Woman Only:** Difficulty with periods? ___________ Date of last period? ___________
- Number of live births? __________ Miscarriages?___________ Abortions? _________
- Currently using birth control? ___________ Have you in the past? __________
- Date of last PAP smear? ______________ Mammogram?__________________

Review of Systems

Please circle any of the conditions or symptoms below, if you have experienced them significantly within the last 6 months.

General
Fatigue Weight change Fever / chills
Weakness Night sweats Insomnia

Skin
Itching Rashes Hair/Nail changes

Head
Headache Trauma Dizziness

Nose
Bleeding Discharge Sinus infections
Allergies Post nasal drip

Eyes
Double vision Blurring Pain
Discharge Poor vision

Mouth/Throat
Sores Gums bleeding Hoarseness
Taste Silver Fillings Pain swallowing

Lungs/Breathing
Wheezing Cough Pain
Shortness of breath Coughing blood

Breasts
Masses Pain Discharge

Cardiovascular
Rapid heart beat Swollen ankles Pain
Angina High-blood pressure Calf pain

Muscles, Joints & Bones
Trauma Pain Arthritis

Gastrointestinal
Appetite Nausea/Vomiting Indigestion
Constipation Diarrhea Hemorrhoids
Blood in stool Gas/belching Pain

Urinary/Urination
Pain Waking at night Incontinence
Frequent Urgency Blood

Sexually Transmitted Diseases
Syphilis Gonorrhea Chlamydia
Herpes Sores / discharge Pelvic pain

Female-Menses
Heavy bleeding Pain Irregular cycle
Menopause Spotting PMS

Male
Testicular pain Swelling Masses
Discharge

Endocrine
Thyroid conditions Hormone medications
Heat / Cold intolerance Diabetes

Blood-Lymphatic system
Anemia Bleeding tendencies
Swollen lymph nodes Transfusions

Neurologic
Fainting Seizures In-coordination
Numbness/tingling Speech problems
Paralysis/Weakness Tremor

Psycho-social
Anxiety Depression Drug/alcohol abuse
Phobia Memory loss

Do you exercise? ________ If yes, please list the types of exercise and the frequency.

1. ____
2. ____
3. ____
4. ____

List the foods you typically consume for breakfast, lunch and dinner.

Breakfast	**Lunch**	**Dinner**

How many times each week do you eat desserts (e.g. cookies, cakes, ice cream, candy etc.)? ________________

Do you drink soda? _______ If yes, how many times each week? ____________________

Do you drink fruit juice? _______ If yes, how many times each week? ________________

Do you drink coffee? ______ If yes, how many cups each day? _____________________

Do you drink alcohol? ______ If yes, how many drinks each week? __________________