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PATIENT REGISTRATION

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

Address _____ Zip _____

Birthdate ____/____/_____ Age _____ Sex _____ **E-mail address** _____

Phone Numbers

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

Employer _____ Occupation _____

Partner's Name _____ Work phone _____

Contact in case of Emergency _____

How did you hear about us? _____

If patient is a minor:

Mother's name _____

Employer _____ Wk Ph _____

Father's name _____

Employer _____ Wk Ph _____

Please read and initial:
Cancellation policy – Cancellations must be made during regular business hours (Monday through Friday). 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: _____

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? _____
- **Women 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? _____