



## NEW PATIENT REGISTRATION INFORMATION

Date \_\_\_\_\_

Doctor you are here to see \_\_\_\_\_

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License No. \_\_\_\_\_ State \_\_\_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse (name) \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

INSURANCE \_\_\_\_\_

Member / I.D. No. \_\_\_\_\_ Group No. \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ Phone \_\_\_\_\_

Is he/she your primary care physician? YES / NO

If not referred by a physician, how did you hear about us? Mailing Website Magazine / Newspaper Television

Referred by Friend \_\_\_\_\_ Other \_\_\_\_\_

Who should be notified in case of an emergency?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### PERSONAL HISTORY

Reason for today's visit? \_\_\_\_\_

First day of last menstrual cycle \_\_\_\_\_

ARE YOU: SINGLE MARRIED DIVORCED SEPARATED Other \_\_\_\_\_

NATIONALITY (Race): Self \_\_\_\_\_ Spouse \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Have you ever been pregnant? \_\_\_\_\_ How many pregnancies? \_\_\_\_\_

Number of: full term live births \_\_\_\_\_ miscarriages \_\_\_\_\_ stillbirths \_\_\_\_\_ premature births \_\_\_\_\_ terminations \_\_\_\_\_

Date of last PAP smear \_\_\_\_\_ Result \_\_\_\_\_ Clinic / Doctor Name \_\_\_\_\_

Date of last Mammogram (if applicable) \_\_\_\_\_ Result \_\_\_\_\_ Place performed \_\_\_\_\_

Have you ever been tested for HIV? \_\_\_\_\_ If yes, when \_\_\_\_\_ Result \_\_\_\_\_

HAVE YOU EVER HAD ...

YES NO

EXPLAIN (Please include dates)

		Major or minor surgical procedure
		Sexually transmitted disease
		Abnormal PAP smear
		Serious injury or accident
		Stroke
		Asthma
		Diabetes
		Hypertension
		Seizures
		Thyroid problems
		Gallbladder / Liver / Kidney problems
		Bleeding tendency / Blood clots
		Migraine Headaches
		Emotional problems
		Tuberculosis
		Hepatitis
		Chicken Pox
		Measles
		Other medical illness

DO YOU CURRENTLY ...

YES NO

EXPLAIN

		Smoke
		Drink excessive caffeine
		Have history of drug abuse
		Drink alcohol or beer regularly
		Perform monthly self breast exams
		Have mitral valve prolapse
		Have an ALLERGY to any medications
		Take any of the following medications: NAME OF MEDICATION & DOSE
		Laxatives
		Blood pressure medication
		Insulin or diabetes medication
		Seizure medication
		Pain pills
		Headache medication
		Thyroid medication
		Antibiotics
		Tranquilizers
		Blood thinner
		Hormones
		Birth Control pill
		Aspirin on a daily basis
		Other

ARE YOU AWARE OF ANY BLOOD RELATIVE WHO HAS OR HAD ...

YES NO

EXPLAIN (If deceased please give ages & dates)

		Stroke
		Cancer
		Type of Cancer
		High Blood Pressure
		Diabetes
		Heart Disease / Heart Attack
		Nervous / Emotional Disorder
		Bleeding tendency
		Liver or Kidney disease
		Lung / breathing problems
		Neural Tube Defect / Down Syndrome
		HIV
		Other