

# PATIENT REGISTRATION & HISTORY

PERSONAL INFORMATION
Name: _____ (First) _____ (Last)
Date of Birth: ____/____/____
Gender: _____ Marital Status: _____
Height: _____ Weight: _____
SSN #: _____
Name of Spouse if Married: _____
Referred by: _____
Who is responsible for your medical bill? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Employer <input type="checkbox"/> Insurance
Employer: _____

COMMUNICATIONS
Phone: _____ (Home) _____ (Work)
Cell: _____
Fax: _____
E-mail: _____
Person to Contact in Emergency: Name: _____ Phone: _____

ADDRESS
Stree: _____ _____
City: _____
State: _____ Zip: _____

## MEDICAL HISTORY

Please check the following applicable items:

### OPERATIONS:

- Appendectomy    Rectal    Tonsillectomy    Gall Bladder    Female Organs    Hernia  
 Others: \_\_\_\_\_

### VACCINATIONS & INJECTIONS:

- Diptheria    Pollo    Tetanus    Typhoid    Small Pox    Spinal Tap or injection  
 Others: \_\_\_\_\_

ACCIDENTS OR FALLS: \_\_\_\_\_

FRACTURES OR DISLOCATIONS: \_\_\_\_\_

HABITS: Sleep (hours) \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Alcohol \_\_\_\_\_

Tobacco \_\_\_\_\_ Exercise \_\_\_\_\_ Hobbies \_\_\_\_\_

Are you now taking any drugs? Please Name them: \_\_\_\_\_

Have you ever had a nervous breakdown? \_\_\_\_\_

Have you or any member of your family been treated for a mental disorder? \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Malaria        | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Alcoholism         |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Typhoid Fever   | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Measles        | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Mental Disorder    |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Lumbago            |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Small Pox      | <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> Eczema             |

**Please Check All of The Following Symptoms You Have NOW:**

**GENERAL SYMPTOMS**

- |                                   |                                      |  |   |
|-----------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fever       | <input type="checkbox"/> Chills        | <input type="checkbox"/> Sweats         |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Loss of Weight |
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Neuralgia     |   |
| <input type="checkbox"/> Allergy  | <input type="checkbox"/> Wheezing    | <input type="checkbox"/> Tremors       |   |

**SKIN**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Skin Eruptions | <input type="checkbox"/> Itching        | <input type="checkbox"/> Bruises Easily | <input type="checkbox"/> Dryness          |
| <input type="checkbox"/> Boils          | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Sensitive Skin | <input type="checkbox"/> Hives or Allergy |

**GENITORINARY SYMPTOMS**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Inability to Control Urine |
| <input type="checkbox"/> Kidney Infection   | <input type="checkbox"/> Kidney Stones     | <input type="checkbox"/> Bed Wetting    | <input type="checkbox"/> Prostate Trouble           |

**RESPIRATORY**

- |  |   |  |                                     |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Chronic Cough       | <input type="checkbox"/> Spitting up Phlegm | <input type="checkbox"/> Spitting up Blood | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Difficult Breathing |   |  |                                     |

**E.E.N.T.**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Nasal Drainage   | <input type="checkbox"/> Enlarged Glands   | <input type="checkbox"/> Crossed Eyes    |
| <input type="checkbox"/> Eye Pain       | <input type="checkbox"/> Deafness         | <input type="checkbox"/> Earache           | <input type="checkbox"/> Ear Noises      |
| <input type="checkbox"/> Ear Discharge  | <input type="checkbox"/> Nose Bleeds      | <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Sore Throat     |
| <input type="checkbox"/> Hoarseness     | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hay Fever         | <input type="checkbox"/> Gum Trouble     |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Tonsillitis       | <input type="checkbox"/> Sinus Infection |

**CARDIO-VASCULAR**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Rapid Beating Heart | <input type="checkbox"/> Slow Beating Heart    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Pain Over Heart     | <input type="checkbox"/> Previous Heart Stroke | <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Poor Circulation   |

**GASTROINTESTINAL SYMPTOMS**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Poor Appetite         | <input type="checkbox"/> Difficult Digestion | <input type="checkbox"/> Excessive Hunger  | <input type="checkbox"/> Belching or Gas      |
| <input type="checkbox"/> Nausea                | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Vomiting of Blood | <input type="checkbox"/> Pain Over Stomach    |
| <input type="checkbox"/> Distention of Abdomen | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Colon Trouble        |
| <input type="checkbox"/> Hemorrhoids(piles)    | <input type="checkbox"/> Intestinal Worms    | <input type="checkbox"/> Liver Trouble     | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Colitis             |  |   |

**MUSCLE & JOINT SYMP.**

- |  |   |  |                                     |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Stiff Muscle      | <input type="checkbox"/> Low Backache   | <input type="checkbox"/> Swollen Joints                              | <input type="checkbox"/> Hernia     |
| <input type="checkbox"/> Painful Tail Bone | <input type="checkbox"/> Foot Trouble   | <input type="checkbox"/> Hand Pain                                   | <input type="checkbox"/> Ankle Pain |
| <input type="checkbox"/> Spinal Curvature  | <input type="checkbox"/> Faulty Posture | <input type="checkbox"/> Leg Pain                                    | <input type="checkbox"/> Keen Pain  |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Wrist Pain     | <input type="checkbox"/> Pain Between Shoulders                      |                                     |
| <input type="checkbox"/> Shoulder Pain     | <input type="checkbox"/> Arm Pain       | <input type="checkbox"/> Numbness or tingling in arms, hands or Legs |                                     |

**FOR WOMEN ONLY**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Painful Menstrual Periods | <input type="checkbox"/> Excessive Flow       | <input type="checkbox"/> Hot Flashes       | <input type="checkbox"/> Irregular Cycle                 |
| <input type="checkbox"/> Cramps or Backache        | <input type="checkbox"/> Previous Miscarriage | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Lumps in Breast                 |
| <input type="checkbox"/> Menopausal Symptom        |   | Are You Pregnant?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |

