Office of Internal Medicine
Patient Registration Form

Date

Patient Information: Please print clearly

Last:______________________ **First**:______________________ **MI**:_______ ☐ **Male** ☐ **Female**

Preferred Name:______________________ **Prefix**:__________ **Suffix**:_________ **DOB**:____ / ____ / _________

SS #: _______ - _____ - _________ **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Other: ______________________

Language: ☐ English ☐ Other: ______________________ **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Billing or Mailing Address: ______________________

City: ______________________ **State**: ______________________ **Zip**: ______________________

Primary Phone: (__________) _________-____________ ☐ Home ☐ Cell
Secondary Phone: (__________) _________-____________ ☐ Home ☐ Cell

Email: ______________________

Emergency Contact: ______________________ **Relationship**: ______________ **Phone**: (_______) _______ - _________

Employment status: ☐ Employed ☐ Not Employed ☐ Retired ☐ Student ☐ Disabled

Employer: ______________________ **Occupation**: ______________________

How did you hear about us? ______________________

Guarantor Information: Responsible Party/Power of Attorney (must have paperwork on file)

Legal Name: ______________________ DOB: ____ / ____ / _________ ☐ Male ☐ Female

SS #: _______ - _____ - _________ Relationship: ______________________ Phone: (_______) _______ - _________

Billing Address: ______________________

City: ______________________ State: ______________________ Zip: ______________________

Employer: ______________________ Occupation: ______________________

Sharing of Medical Information

I give the Office of Internal Medicine permission to discuss my medical condition with the following individuals, if none please select none:

(You must add your spouse or your emergency contact if you wish for us to be able to talk with them.)
(Ask our Receptionist for additional space for Sharing of Medical Information.)

Name: ______________________ Relationship: ________________ Phone: __________________

Name: ______________________ Relationship: ________________ Phone: __________________

☐ None

Communication

I would like Voicemails to be left on the phone number I provided: ☐ Yes ☐ No

If Yes I specifically authorize Voicemails to be left for: ☐ Appointments ☐ Results ☐ Medication Issues

Primary Insurance

Name of Insurance: ______________________

Name of Policy Owner: ______________________ Policy Owner's DOB: ____/____/_________

Policy Owner's Employer: ______________________ Relationship to Patient: : ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance

Name of Insurance: ______________________

Name of Policy Owner: ______________________ Policy Owner's DOB: ____/____/_________

Policy Owner's Employer: ______________________ Relationship to Patient: : ☐ Self ☐ Spouse ☐ Parent

Office of Internal Medicine

Medical History

Patient Name: ______________________________ **DOB:** ____ / ____ / ________

Medical History: Please check all that apply

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular heartbeat)
- ☐ Benign Prostatic Hypertrophy (BPH)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Gastro Esophageal Reflux Disease (GERD)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol (Hypercholesterolemia)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: ________________
- ☐ **None**

Surgical History: Please check all that apply

- ☐ Appendix Removed (Appendectomy)
- ☐ Bladder Removed (Cystectomy)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Lumpectomy (Right, Left, Both)
- ☐ Breast Mastectomy (Right, Left, Both)
- ☐ Colectomy
- ☐ Colon: Colostomy
- ☐ Coronary Artery Bypass
- ☐ Joint Replacement, Knee (Right, Left, Both)
- ☐ Gallbladder Removed (Cholecystectomy)
- ☐ Heart: __________
- ☐ Hysterectomy
- ☐ Joint Replacement, Hip (Right, Left, Both)
- ☐ Liver: Liver Removal (Hepatectomy)
- ☐ Kidney: _________
- ☐ Pancreas: Pancreas Removal (Pancreatectomy)
- ☐ Prostate: Prostate Removal (Prostatectomy)
- ☐ Skin Cancer
- ☐ Spleen: Spleen Removal (Splenectomy)
- ☐ Testicles: Testicle Removal (Orchiectomy)
- ☐ Other: ___________________
- ☐ **None**

Family History: Please indicate whether Mother, Father, Siblings, Grandparents

Heart Disease: ____

High Blood Pressure: ______________________________________

Diabetes: ____

Cancer: ____

Other Disease (Please Specify): ___________________________

____

Top 3 Complaints

1.

2.

3.

Pharmacy: Please give as much information as possible

Name	Location	Phone Number

Patient Name: ____ DOB: ____ / ____ / _________

Medications: Please list Medication Name

____

____

____

____ ☐ **None**

Allergies: Please list all allergies

__________ NO KNOWN ALLERGIES

Social History: Please check one

Tobacco Use: ☐ Never ☐ Quit ☐ Less than daily ☐ Daily

____

Cigarettes Pipe Cigars Chew Vape

Alcohol Use: : ☐ Never ☐ Yes: How much and how often______________________

Review of Systems

	Y	N		Y	N		Y	N
GENERAL			STOMACH			NEUROLOGICAL		
Headache			Black/Bloody Stools			Loss of strength		
Lethargy/Weakness			Heartburn/Indigestion			Tremors		
Chills/Night sweats			Change in bowel habits			Headaches		
Fever			Abdominal pain			Memory loss		
Fainting spells/unconscious			Nausea/vomiting			Confusion		
Weight loss/gain			Constipation			PSYCHIATRIC		
Dizziness			HEMATOLOGIC			Anxiety/Depression		
EYES			Bleed/bruise easily			Mood swings		
Wears glasses/contacts			Enlarged glands			Difficulty sleeping		
Eyesight worsening						BREAST/MENSTRUAL		
Double vision						Endometriosis		
Eye pain			KIDNEY/ PROSTATE			Are you pregnant?		
EARS/NOSE/THROAT			Nighttime			Irregular menstrual period		
Difficulty Hearing			Burning/Frequency			Breast discharge		
Ringing in ears			Blood in urine					
Congestion/sneezing			Erectile Dysfunction					
Sinus trouble/hay fever			Abnormal Discharge					
Nose bleeds			SKIN					
Sore throat or tongue			Rashes/Sores					
HEART			Birthmarks					
Chest pain			MUSCLE/BONE					
Shortness of Breath			Back pain					
Heart murmur			Neck pain					
Heart racing/palpitations			Joint pain/swelling					
Irregular heart beat			Stiffness					
Swollen feet/ankles								
ENDOCRINE								
Excessive tiredness								
Hair loss								