Emerald Valley Wellness Clinic
300 N. Mill St., Suite A
Creswell, OR 97426
Office: 541-895-5300 • Fax: 541-895-5319

PATIENT REGISTRATION & MEDICAL HISTORY

Date:____________

Full Legal Name: ______________________________________ (*Please circle one*): Gender: *Male* *Female*
Last First MI
Mailing Address: ______________________________________ Social Status: *Sing* *Mar* *Div* *Wid*
City__________________________ State_______ ZIP__________
Phone Number:___________________ Date of Birth: __________________ Age: ______________
Cell Phone: ______________________ E-mail: ____
Work Phone: ____________________ *Employment*:____
Social Security No.:__________________________ Religious faith *(optional)*:____________________
Notify in case of Emergency: ______________________________________ *Relation*:______________
Phone: _________________________________ *Cell Phone:* _____________________________________

Health Concerns:
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Past Diseases: ___________________________
____
____
____

Operations: _____________________________
____
____
____

Accidents & Injuries: _____________________
____
____
____

Allergies:(Please specify: medications, foods, environmental, pets, ect.)
____
____
____

Medications, Vitamins, Herbs: _______________
____
____
____
____

Habits:
Tobacco__________packs/day
Alcohol__________drinks/week
Caffeine__________cups/day
Exercise_______________
Sleep_________hours/night
Is it restful? Y or N

Family History: *Which of your blood relatives have had?*
High blood pressure______________________
Heart disease ___________________________
Emphysema_____________________________
Allergies/Asthma_________________________
Arthritis _______________________________
Diabetes_______________________________
Cancer ________________________________
Mental illness___________________________
Kidney problems _________________________
Epilepsy or seizures_______________________
Alcohol or drug abuse _____________________
Hereditary conditions *(specify)*________________
Other illnesses ___________________________
____

Dietary History:
Breakfast – time___________________________
*Usual menu*______________________________
Lunch – time _____________________________
*Usual menu*______________________________
Supper – time_____________________________
*Usual menu*______________________________
Snacks – *(frequency)*_______ *(type)* ___________
Sweets – *(frequency)*_______ *(type)* ___________
Water__________________glasses/day

Immunizations: *(circle vaccines completed)*
DPT Polio MMR Tetnus Pneumonia
Influenza Hepatitis Other__________
*Dates*____________________________________

Education ________________________________
Military___________________________________
Foreign Travels: ___________________________
Children: *(include ages)*_____________________
____
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