Pre-registration Patient Medical History Form

Name: _____ DOB _____|_____|_____

Address: _____ Home Ph. # _____

E-mail address: _____ Cell Ph. # _____

Marital status: (Circle one) Married Single Widow Separated Occupation: _____

Tobacco Use: (Circle one) Never Past Use Current Use If Past User when did you Quit: _____

Current user: Packs per day _____ Number of years _____ Plan to quit? (Circle one) Yes No

Secondhand tobacco exposure:(Circle one) Yes No Smokeless tobacco use:(Circle one) Yes No

Alcohol use: (Circle one) Yes No If Yes, how much ? Drinks/Day _____ Days/Week _____

Exercise: (Circle one) Yes No If yes, how often ? Days/Week _____ Minutes/Day _____

Current Medications: prescription or non-prescription

Name	Strength	How often taken

Medication allergies:

Name of Medicine	Reaction Type

Do you have other allergies? (Environmental, foods, dyes, insect stings) _____

_____

Current Medical Problems:

Name	Date of onset

Do you see other Specialists currently? Provide Name, Speciality and Phone numbers.

_____

Past Medical Medical/Surgical problems or Hospitalizations:

Name	Date

Family Medical History:

Disease	Relation	Alive/Diceased (A/D)	Age
Diabetes			
Hypertension			
High Cholesterol			
Heart Attack/Heart Failure			
Cancer			
Stroke			
Depression			

Screening Tests: (Date of last screening month/year)

Colonoscopy: _____|_____ PSA: _____|_____ Mammogram: _____|_____

PAP Smear: _____|_____ Bone Density: _____|_____

Immunizations: (Date of last received month/year)

Tetanus/Td: _____|_____ Pneumonia: _____|_____ Influenza: _____|_____

Hepatitis B: _____|_____ Shingles: _____|_____ TB test (PPD): _____|_____

Do you have Living Will? (Circle one) **Yes No Do you have an Advance Directive? Yes No**