PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ PLEASE PRINT Home Phone (____)_____

Patient_____
Last Name First Name Middle Initial

Street Address_____City_____State_____Zip_____

E-mail_____Cell Phone (____)_____

Sex ☐ M ☐ F Age_____ Birthdate_____

Employer/School_____ Occupation_____

Employer/School Phone_____

Emergency Contact (Name and Phone)_____

Insurance Company_____Group Number_____

MEDICAL HISTORY

Physician's Name_____Date of Last Physical_____

List any previous surgeries/dates: _____

_____

Do you have any drug allergies, or have you ever had an adverse reaction to any medication/medical treatment/anesthesia?

☐ Yes ☐ No If so, what?_____

_____

Are you taking any medication at this time? _____If so, what? _____

_____

Vitamins/Supplements?_____

_____

Blood Thinners (Aspirin, Advil, Aleve, etc.)? _____

Have you taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due Date_____

Are you nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Have you ever had any of the following? (**check boxes that apply**)

	Recent Weight Loss/Gain
	Fever, Chills, Night Sweats
	High Cholesterol
	Headache
	Osteoarthritis
	Rheumatoid Arthritis
	Gout
	Hip or Spinal Fractures
	Back Pain
	Sciatica
	Shoulder Pain
	Heart Disease/Heart Attack/Chest Pain
	High Blood Pressure
	Rapid or Irregular Pulse
	Pacemaker
	Mitral Valve Prolapse
	Paralysis/Numbness
	Strokes (TIA)
	Anemia
	Bleeding
	Blood Clots/Phlebitis
	Blood Disease
	Asthma or Breathing Problems
	Pneumonia
	Tuberculosis
	Shortness of Breath
	COPD
	Hepatitis
	Liver Disease
	Diabetes
	Thyroid Disease
	Kidney Disease
	Hiatal Hernia/Esophageal Reflux
	Ulcers
	Change in Bowel Function
	Blood in Stool
	Change in Bladder Function
	Ear or Hearing Problems
	Glasses or Contacts
	Sore Throat
	Nasal Dryness or Congestion
	Anxiety
	Depression

If you checked any of the above boxes that apply, please explain:

Family History

Check family members who have been diagnosed with any of the following:

Relationship:

- ☐ Asthma/Breathing Problems _____
- ☐ Anesthesia/Surgical Complications _____
- ☐ Bleeding _____
- ☐ Blood Clots/Phlebitis _____
- ☐ Cancer _____
- ☐ COPD Chronic Obstructive Pulmonary Disease _____
- ☐ Diabetes _____
- ☐ Gout _____
- ☐ Heart Disease/Heart Attack/Chest Pain _____
- ☐ Hepatitis/Liver Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Osteoarthritis _____
- ☐ Rheumatoid Arthritis _____
- ☐ Strokes/Transient Ischemic Attacks (TIA) _____
- ☐ Thyroid Disease _____
- ☐ Other/Explain _____

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Exercise/Sports: ☐ Cycling ☐ Gym Activities ☐ Running ☐ Swimming
☐ Other_____; _____times per week

Do you use any of the following Tobacco products:
☐ None ☐ Cigarettes ☐ Cigars ☐ Smokeless Tobacco
☐ Tobacco use for ____ years Packs per day _____
☐ Quit Tobacco (when)_____

Do you drink alcohol? ☐ Yes ☐ No
☐ Less than 12 drinks per year
☐ Light (1-13) drinks per month
☐ Moderate (14-30) drinks per month
☐ Heavy (more than two drinks per day)

Do you have a history of recreational drug use?
☐ Yes Type/Name of Drug_____
☐ No

Do you take Calcium supplements? ☐ Yes ☐ No

Did either if your parents have osteoporosis? ☐ Yes ☐No ☐ Unknown

Have you lost an inch or more in height? ☐ Yes ☐No ☐ Unknown

Have you ever had/taken?
☐ Chemotherapy ☐ Steroids ☐ Fractured Bones (as an adult)
☐ Thyroid Medications ☐ Immunosuppressive Medications

_____
_____
_____
_____
_____