ADULT

ADULT REGISTRATION

Name: ____

Male/Female: _____ SSN: __________________________ Age: __________ Date of Birth: _____________________

Mailing Address: ____

City: _____________________________________ State: _____________ Zip: ______________________________

Physical Address: ____

City: _____________________________________ State: _____________ Zip: ______________________________

Home Phone: _______________________ Cell: __________________________ Work: ______________________

E-mail address: ____

Best way to reach you: □Home □Cell □Work Can we leave a message? □Y □N

Marital Status: □ Married □ Single □ Partnered □ Separated □ Divorced □ Widowed

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other □ Declined

Race: □ Native American □ Asian □ Black □ White □ Other □ Declined

Preferred Language (*if other than English*): ____________________________

Emergency Contact/Relationship: _______________________________________ Phone: ______________________

Guarantor of Bill/Relationship: ____ Phone: ______________________

Insurance Carrier/Employer: ____

Policy Holder's Name: _____________________________ DOB: ______________ SSN: ________________________

PAST MEDICAL HISTORY

Pharmacy/Location: ____

Chronic Medical Problems:

□ High Blood Pressure	□ High Cholesterol	□ Heart Disease	□ Heart Failure	□ Heart Attack
□ Sleep Apnea	□ COPD (Emphysema)	□ Asthma	□ Pulmonary Fibrosis	□ Seasonal Allergies
□ GERD/Heartburn	□ IBS	□ Chronic Constipation	□ Chronic Diarrhea	□ Stomach Ulcers
□ Diabetes	□ Low Thyroid	□ Osteoporosis	□ PCOS	□ Low Testosterone
□ Low Back Pain	□ Neck Pain	□ Wrist Pain	□ Foot/Ankle Pain	□ Shoulder Pain
□ Depression	□ Anxiety	□ Insomnia	□ Substance Abuse	□ Memory Loss
□ Anemia	□ Blood Clots	□ Rheumatoid Arthritis	□ Lupus	□ Gout
□ Cataracts	□ Glaucoma	□ Blindness	□ Hearing Loss	□ Ear Infections
□ Kidney Disease	□ Kidney Stones	□ Recurrent UTIs	□ Erectile Dysfunction	□ Enlarged Prostate
□ Menstrual Problems	□ Ovarian Cysts	□ Infertility	□ Endometriosis	□ Incontinence
□ Migraines	□ Other Headache	□ Stroke	□ Seizure Disorder	□ Multiple Sclerosis

□ Current Cancer, Type? ____

□ Previous Cancer, Type? ____

Other Medical Problems: ____

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Current Medications (if you have brought a medication list, you may skip this section):

Medication Name	Dose	Frequency?

Drug Allergies (please include your reaction):

□ Penicillins _________________ □ Sulfa _____________________ □ Codeine ______________________

□ Other (please list): ____

____

Surgeries (include approximate dates):

□ Appendectomy ___________ □ Hysterectomy ____________ □ Ovaries Removed (L R B) ___________

□ Cataracts (L R B) ___________ □ Tubal Ligation ____________ □ Vasectomy ____________

□ C-section ________________ □ Hernia __________________ □ Breast Implants _____________

□ Breast Biopsy ____________ □ Cervix Biopsy ____________ □ Gallbladder Removed ____________

□ Orthopedic Surgery (Type?) ____

□ Neck or Back Surgery (Type?) ____

□ Other (Type?) ___________ ____

____

Overnight Hospitalizations (include approximate dates and location):

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Have you seen any specialist physicians in the past 5 years? (include name and location):

□ Gynecologist ______________________________
□ Urologist (prostate/kidney stones)______________________________
□ Gastrointerologist (colon/stomach)______________________________
□ Neurologist (brain) ______________________________
□ Orthopedist ______________________________
□ Rheumatologist ______________________________
□ Optometrist ______________________________
□ Cardiologist ______________________________
□ Pulmonologist (lungs) ______________________________
□ Podiatrist (feet) ______________________________
□ Ear/Nose/Throat ______________________________
□ Psychiatrist ______________________________
□ Endocrinologist ______________________________
□ Pain Management ______________________________
□ Other ______________________________

VACCINE HISTORY (*when was your last…?)*

Tetanus: ______________________________
Flu: ______________________________
Pneumovax (Pneumonia) :______________________________
Prevnar (Pneumonia): ______________________________
Shingles: ______________________________
Gardasil (HPV): ______________________________
Menactra (Meningitis): ______________________________

HEALTH MAINTENANCE: *(when was your last… and where…?)*

Physical Exam: ______________________________
Colonoscopy: ______________________________
Mammogram: ______________________________
Pap Smear:______________________________
Lung Cancer Screening: ______________________________
Dexa (Bone Density): ______________________________
Eye Exam:______________________________

SOCIAL HISTORY

Marital Status: □ Married □ Single □ Partnered □Separated □ Divorced □ Widowed
Sexual Orientation: □ Heterosexual □ Homosexual □Bisexual □ Other
Occupation: ______________________________ Place of Work: ______________________________
Spouse/Partner's Name: ______________________________
Children's Names: ______________________________
Who lives with you in your home? ______________________________
Level of Education: □ High School or GED □ Some College □ College Degree ______________________________

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Tobacco Use:	Illicit Drug Use:	Alcohol Use:
□ Never □Current □ Former (Quit Date: ____________) □ Smoke □ Dip/Chew How much? _________________________ How many years? ____________________	□ Never □ Former □ Current If you use drugs, what kind? ______________________________________ How often? ______________________________________	□ Never □ Rarely □ Occasionally □ Frequently When you drink, how much do you drink? __________________________

FAMILY HISTORY

Condition			**Type**	**Relationship (mother, father, child, etc)**
Diabetes	Y	N		
Cancer	Y	N		
Thyroid Disorder	Y	N		
Lung Disease	Y	N		
Heart Disease	Y	N		
High Blood Pressure	Y	N		
High Cholesterol	Y	N		
Stroke	Y	N		
Kidney Disease	Y	N		
Urinary Disease	Y	N		
Liver Disease	Y	N		
Gastrointestinal Disease	Y	N		
Psychiatric Disorder				

Please list any other medical conditions that run in your family: ____
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