NEW PATIENT REGISTRATION FORM

Please print the following information

PERSONAL INFORMATION

Date Today: .....

Name ..... Birth Date ..... Sex .....
First M.I. Last

Address .....
Street Address P.O. Box/Apt# City State Zip Country

Marital Status..... Race ..... Education..... Email.....

Phone: (Home) .....(Work)..... (Cell) .....

Closest Relative .....

(include address) .....

Relative Phone: ..... Spouse/Sig. Other ..... Referred by.....

Employer ..... Occupation.....

Medications, Herbs, ...

Home Remedies, etc. .....

Allergies (including medication).....

Diet (please describe)- Breakfast .....

Lunch.....

Dinner.....

Exercise (please describe) .....

HOSPITALIZATIONS: YEAR OPERATION/ILLNESS NAME OF HOSPITAL CITY AND STATE

First.....

Second .....

Third .....

Fourth .....

CHIEF COMPLAINT

Reason for this visit .....

Was there an initiating event or was anything different within 6-12 months before the onset of the problem?

.....

.....

MEDICAL HISTORY

☑ **CHECK** every condition that you have *ever had.* ☑ **CIRCLE** conditions currently present. ☑ **WRITE** the **age of onset. 7 y/o**

EYES
- ☐ Failing vision
- ☐ Double or blurred vision
- ☐ Squinting/"crossed" eyes/
- ☐ Asymmetric gaze
- ☐ Eye pain
- ☐ Eye infections
- ☐ Lose place when reading
- ☐ Poor reading comprehension
- ☐ Eyestrain or fatigue from reading
- ☐ Headache from reading
- ☐ Glasses or contacts
- ☐ Monovision/Progressive lenses

ENT
- ☐ Decreased hearing
- ☐ Loud voice
- ☐ Snoring/Mouth breathing
- ☐ Ringing/Buzzing in ears
- ☐ Ear infections
- ☐ Allergies/Hay fever/Runny nose
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Frequent sore throats
- ☐ Prolonged hoarseness
- ☐ Speech problems

CARD-PULM
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Shortness of breath on exertion
- ☐ Shortness of breath on lying flat
- ☐ Chest pains
- ☐ Heart murmurs
- ☐ Palpitations
- ☐ Swollen ankles
- ☐ Fainting spells
- ☐ Leg pain when walking
- ☐ Varicose veins/Phlebitis

GI
- ☐ Eating disorder
- ☐ Recent loss of appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Persistent nausea/vomiting
- ☐ Ulcers
- ☐ Chronic abdominal pain
- ☐ Recent change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black or tarry stools
- ☐ Red blood in stools
- ☐ Hemorrhoids
- ☐ Diverticulosis
- ☐ Gall bladder trouble
- ☐ Jaundice/Hepatitis
- ☐ Hernia

ENDO
- ☐ Chronic fatigue
- ☐ Recent weight loss
- ☐ Excessive weight gain
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Diabetes

NEURO
- ☐ Convulsions/Seizure
- ☐ Stroke
- ☐ Tremors
- ☐ Muscle weakness
- ☐ Numbness/Tingling sensation
- ☐ Frequent headaches
- ☐ Clumsiness

MS
- ☐ Joint pain
- ☐ Scoliosis/Kyphosis
- ☐ Arthritis
- ☐ Gout
- ☐ Cold or numb feet
- ☐ Involved in contact sports

DERM
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Unusual moles

PSYCH/EMOTIONAL
- ☐ Difficulty Sleeping
- ☐ Nightmares
- ☐ Nervousness/Anxiety
- ☐ Stress
- ☐ Depression
- ☐ Memory loss
- ☐ Moodiness
- ☐ Phobias
- ☐ Nail biting/thumb sucking
- ☐ Bad temper/breath holding/
- ☐ Jealousy

ILLNESSES
- ☐ Mumps
- ☐ Measles
- ☐ German measles
- ☐ Chicken pox
- ☐ Polio
- ☐ Scarlet fever
- ☐ Rheumatic fever
- ☐ TB
- ☐ Meningitis

HABITS
- ☐ Alcoholism
- ☐ Alcohol .....
- ☐ Cigarette .....packs/day
- ☐ Coffee/Tea .....cups/day

HEME
- ☐ Anemia
- ☐ Malaria
- ☐ Bruise easily/Bleeding
- ☐ Mononucleosis
- ☐ Unexplained lumps
- ☐ Fever/Chills/Excessive sweating

GU
- ☐ Bed wetting
- ☐ Bladder infections
- ☐ Kidney infection
- ☐ Pain on urination
- ☐ Poor control of urination
- ☐ Decreased force of urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Discharge from penis or vagina
- ☐ Sexually transmitted disease

FEMALE ONLY:

Number of pregnancies .....
Number of live births.....
Number of miscarriages .....
Method of birth control.....
Age of onset of menses.....
Flow: ☐ Light ☐ Moderate ☐ Heavy
- ☐ Period Not Regular
- ☐ Length of Flow .....
- ☐ Length of Cycle.....
- ☐ Pain/bleeding with intercourse
- ☐ PMS (medium to severe)

STRESS

Check any of the following that occurred in your family the past year:

☐ Marriage ☐ Births ☐ Serious illness
☐ Divorce ☐ Deaths ☐ Separation
☐ Job loss ☐ Move ☐ Other.....

DENTAL
- ☐ Orthodontic treatment
- ☐ Dental extractions
- ☐ Crowns
- ☐ Root canal work
- ☐ Fillings
- ☐ Bridgework
- ☐ Retainer/Night guard
- ☐ Gum problems

☐ Grind teeth

TRAUMA

List all following with age of occurence

Falls. .....

.....

.....

.....

Bumps. .....

.....

..... Sprains/Strains. .....

.....

.....

.....

Concussions .....

.....

Broken bones .....

.....

..... Accidents .....

.....

.....

.....

OTHER

.....

.....

.....

PEDIATRIC Pediatric section for patients under 18 years old only.

PREGNANCY (Mother)

Mothers age when pregnant .....

What number pregnancy was this? .....

Number of abortions/Miscarriages? .....

Number of live births? .....

☐ Unplanned pregnancy
☐ Complications
☐ In vitro
☐ Artificial Insemination
☐ Amniocentesis

Number of ultrasounds .....

Medications during pregnancy:

.....

.....

☐ Trauma during the pregnancy
☐ Illnesses during pregnancy

LABOR

☐ False labor

How long was active labor .....

☐ Difficult labor
☐ Pitocin
☐ Pain medication
☐ Epidural or spinal anesthesia

DELIVERY

When was the baby born relative to the due date? .....

Baby's position .....

☐ C-section
☐ Forceps
☐ Episiotomy
☐ Vacuum extraction
☐ Cord wrapped around the neck
☐ Difficult/traumatic delivery
☐ Meconium staining

NEWBORN

What was the birth weight .....

APGARs: 1 min. .....5 min. .....

☐ Head asymmetrical/uneven at birth
☐ Unusual cry at birth

NUTRITION

☐ Breast
☐ Formula .....
☐ Other .....
☐ Did NOT nurse immediately after birth
☐ Difficulty nursing

INFANT

☐ Spiting up
☐ Rigidly arches backwards
☐ Muscle tone feel loose or floppy
☐ Muscle tone feel too tight or rigid
☐ Torticollis (head and neck side-bent)
☐ Colic
☐ Age of first illness
☐ Helmet use for uneven head

BABY

Age first sleep through night .....

☐ Used a walker or any similar device
☐ Used a swing
☐ Growth and development problems

What age did your child:

Sit up ..... Creep .....

Crawl ..... Cruise .....

Walk ..... Talk .....

SENSITIVITIES

☐ Easily startled?
☐ Food sensitivities
☐ Picky eater
☐ Difficulty wearing certain clothing

MOTOR SKILLS

☐ Clumsiness
☐ Difficulty drawing a straight line, circle, square, complex figure (age appropriate)

SCHOOL

☐ Poor grades in school?
☐ Homework difficult
☐ Poor concentration/short attention span
☐ Doesn't get along with classmates

EXPOSURE/HABITS

☐ Possible lead exposure (old home/plumbing/peeling paint)
☐ Smokers in household
☐ TV – hours per day .....
☐ Computers – hours per day .....
☐ Video games – hours per day .....
☐ Suck finger/thumb/lip/pacifier
☐ Nail biting

Your relationship to child .....

Location of birth .....

Is the child yours by:

☐ Birth ☐ Adoption ☐ Marriage

Other .....

Are both biological parents raising the child ☐ Yes ☐ No

Parents: ☐ Unmarried ☐ Married ☐ Separated ☐ Divorced

Who lives in the home?

.....

.....

Father's professions .....

Mother's professions .....

Is your child:

☐ Irritable ☐ Aggressive ☐ Shy

SIBLINGS

List all siblings

.....

.....

.....

.....

OTHER MEDICAL TREATMENT: List all Physicians from whom you are currently receiving treatment along with the condition(s).

PHYSICAN NAME	ILLNESS(ES)	TREATMENT PROGRAM
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

FAMILY HISTORY Please look down the list of diseases and check any listed family member that applies.

Relative / Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
AutoImmune Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Congenital Anomaly/Birth defect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food allergy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hearing disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Immune disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental retardation/Learning disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis/Kyphosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thryroid dusorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tobacco use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Death before age 56	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

IMMUNIZATIONS Please list any type of immunization reaction or adverse effect.

Immunization	Describe reaction including severity, length of time, and age.
DPT	
Tetanus booster	
Polio	
MMR	
Hib	
Varicella	
Prevnar	
Hepatitis A	
Hepatitis B	
Other	