Personalized HealthCare Patient Registration

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First Name		Middle	Last Name		DOB	Age
Sex	SSN	Race	Ethnicity	Marital Status		Language
Address		City		State	Zip Code	
Cell Phone		Home Phone		Work Phone		
Email Address		Occupation				
Employer				Phone		
Employer Address		City		State	Zip Code	

SPOUSE/GUARDIAN/OTHER__________

First Name	Middle	Last Name	
Address	City	State	Zip Code
Cell Phone	Home Phone	Work Phone	

INSURANCE INFORMATION

Primary Insurance	Policy Number		Group Number
Policy Holder's Name	DOB		Home Phone
Insurance Claims Address	City	State	Zip
Secondary Insurance	Policy Number		Group Number
Policy Holder's Name	DOB		Phone
Insurance Claims Address	City	State	Zip

SOCIAL HISTORY

Do you live alone? Yes ☐ No☐	Highest Level of Education	Occupation

Do you have children? Yes ☐ No ☐ How many male children? How many female children?	Alcohol drinks/day	Caffeine Consumption Cups per day?

Have you ever smoked cigarettes or cigars? ☐Yes☐No	Packs /day	How many years did you smoke? When did you quit?

DRUG, FOOD OR ENVIROMENTAL ALLERGIES

Allergy to:	Reaction:

MEDICATIONS/SUPPLEMENTS

Medication/Supplement	Dose	Frequency

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HEIGHT AND WEIGHT

Current height	☐Recent weight gain	If so, how much?
Current weight	☐Recent weight loss	If so, how much?

PAST PROBLEMS, HISTORY, HOSPITALIZATIONS, AND PREVIOUS DIAGNOSIS

	Date
	Date
	Date
	Date
	Date
	Date

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	Date
	Date

PHYSICIANS YOU SEE REGULARLY

1.	5.
2.	6.
3.	7.
4.	8.

SCREENINGS

Colonoscopy	Date	Mammogram	Date
Glaucoma	Date	Pap-Smear	Date
Bone Density	Date	Eye Exam	Date
Rectal Exam	Date	Other	Date

VACCINE HISTORY

☐Tetanus	Date	☐Flu			Date
☐Shingles	Date	☐Prevnar			Date
☐Pneumovax	Date	☐Hep A	Date	☐HepB	Date
☐Other	Date				

FAMILY MEDICAL HISTORY

Father living	Current age (or age at death)	List cause of death or unknown

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Mother living	Current age (or age at death)		List cause of death or unknown
Cancer	Mother	Father	Grandparent/sibling
Diabetes	Mother	Father	Grandparent/sibling
Heart Disease	Mother	Father	Grandparent/sibling
High Blood Pressure	Mother	Father	Grandparent/sibling
Stroke	Mother	Father	Grandparent/sibling

REVIEW OF SYSTEMS

General Health - Check All That Apply			
☐Change in appetite	☐Chills	☐Fatigue	☐Fever
☐ Headaches	☐Lightheadedness	☐Night sweats	☐Sleep disturbance
Allergy/Immunology			
☐Blistering of skin	☐Congestion	☐Cough	☐Hives
☐Itching	☐Rash	☐Sneezing	☐Unusual reaction to meds
☐Watery eyes	☐Wheezing		
☐Blurred vision	☐Contact lenses	☐Corrective lens	☐Diminished visual activity
☐Discharge	☐Dry eye	☐Eye Pain	☐Other eye problems
☐Flashes of light in the visual field	☐Red eye		
ENT			
☐Blocked ear	☐Dentures	☐Decreased hearing	☐Decreased sense of smell
☐Deviated septum	☐Difficulty swallowing	☐Dry mouth	☐Ear pain
☐Ear problems	☐Hearing screen	☐History of broken nose	☐Masses
☐Mouth breathing at night	☐Nose/Throat problems	☐Nosebleed	☐Oral or facial skeletal surgery
☐Pain	☐Ringing in the ears	☐Sinus pain	☐Snoring
☐Sore throat	☐Swollen glands		
Endocrine			
☐Cold intolerance	☐Diabetes	☐Difficulty sleeping	☐Dizziness

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☐Excessive sweating	☐Frequent urination	☐Vaginal itching/discharge	☐Heat intolerance
☐Hair loss	☐Painful menses	☐Hot flashes	☐Irregular menses
☐Thyroid problems	☐Weakness	☐Vaginal bleeding between menses	☐Heavy vaginal bleeding
Respiratory			
☐Asthma	☐Breathing problems	☐Chest pain	☐Cough
☐Hemoptysis	☐Pain with inspiration	☐COPD	☐Shortness of breath at rest
☐Shortness of Breath during exercise	☐Sputum production	☐Tuberculosis	☐Wheezing
Breast			
☐Nipple discharge	☐Breast biopsies	☐Breast lump	☐Breast pain
☐Breast swelling	☐Burning nerve pain	☐Chest Muscle pain	☐Fever
☐Gland swelling	☐Rashes	☐Red skin	☐History of breast cancer
☐Breast Asymmetry			
Cardiovascular			
☐Chest pain - rest	☐Chest pain- exertion	☐Pain in legs on exertion	☐blue or grey skin color
☐Difficulty lying flat	☐Dizziness	☐Shortness of breath on exertion	☐Heart murmur
☐High blood pressure	☐Irregular heart beat	☐Orthopnea	☐Palpitations
☐Rheumatic fever	☐Shortness of breath	☐Swelling-hands, feet	☐Weakness
Gastrointestinal			
☐Abdominal pain/swelling	☐Blood in stool	☐Change - bowel habits	☐Colitis
☐Constipation	☐Decreased appetite	☐Diarrhea	☐Difficulty swallowing
☐Exposure to hepatitis	☐Heartburn	☐Hepatitis	☐Rectal bleeding
☐Stomach problems	☐Vomiting	☐Weight loss	☐Difficulty swallowing
Hematology			
☐Anemia	☐Bleeding problems	☐Groin mass	☐Easy bruising
☐Prolonged bleeding	☐Recent transfusion	☐Swollen glands	☐Weakness
Men only			
☐Difficulty initiating stream	☐Dribbling after urination	☐Hard testicle	☐Hernia
☐Hypospadias	☐Lump in groin	☐Penile discharge	☐Rash or blister on penis
☐Scrotal pain	☐Scrotal swelling	☐Undescended Testicle	
Genitourinary			
☐Abdominal pain/swelling	☐Blood in urine	☐Difficulty urinating	☐Frequent urination

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☐Kidney problems	☐Painful urination	☐Painful intercourse	☐Pain in lower back
Musculoskeletal			
☐Arthritis	☐Back problems	☐Carpal tunnel	☐History of gout
☐Joint stiffness	☐Leg cramps	☐Muscle aches	☐Pain in shoulder
☐Painful joints	☐Sciatica	☐Swollen joints	
☐Trauma to hips	☐Trauma to knees	☐Trauma to ankles	☐Weakness
Peripheral Vascular			
☐Absent pulses in hand	☐Absent pulses in feet	☐Blanching of skin	☐Blood clots in legs
☐Cold extremities	☐Decreased sensation in extremities	☐Pain or cramping in legs after exertion	☐Painful extremities
☐Ulceration of feet	☐Numbness in extremities		
Podiatric			
☐Achilles pain/redness	☐Achilles swelling	☐Ankle pain	☐Ankle swelling
☐Ball of foot pain	☐Big toe pain	☐Big toe swelling	☐Difficulty walking
☐Foot swelling			
Skin			
☐Acne	☐Blistering of skin	☐Discoloration	☐Dry skin
☐Eczema	☐Excessive sun exposure	☐Hives	☐Itching
☐Hair changes	☐Keloid formation	☐Masses	☐Moles
☐Nail changes	☐Photosensitivity	☐Rash	☐Scaly lesions of skin
☐Skin cancer	☐Skin lesions	☐Skin oozing	☐Treated with radiation
Neurologic			
☐Balance difficulty	☐Coordination	☐Difficulty speaking	☐Dizziness
☐Fainting	☐Gait abnormality	☐Headache	☐Irritability
☐Loss of strength	☐Loss of use of extremity	☐Low back pain	☐Memory loss
☐Paralysis	☐Seizure	☐Stroke	☐Tics
☐Tingling/Numbness	☐Transient loss of vision	☐Tremor	
Psychiatric			
☐Anxiety	☐Hallucinations	☐Delusions	☐Depressed mood
☐Difficulty sleeping	☐Eating disorder	☐Loss of appetite	☐Mental or physical abuse
☐Nervous breakdown	☐Psychiatric condition	☐Stressors	☐Substance abuse Specify_____________
☐Suicidal thoughts			

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Exercise			
Type of Exercise	Duration	Times per Week	Intensity of Scale

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