Patient Registration and Medical History Form

PLEASE ***PRINT*** AND COMPLETE ALL AREAS

______________ ______________ ______ ___/___/___ ______

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

______________ ______________ ______ ______

Address | City | State | Zip

___/___/___ ______________ ______________ ______________

Patient SSN | Home Phone | Cell Phone | Patients Email

______________ ______________ ______________

Emergency Contact | Phone Number | Relationship

RACE:

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic
- ☐ White/Caucasian
- ☐ Other: ____________
- ☐ Declined

LANGUAGE:

- ☐ English
- ☐ Spanish
- ☐ Other: ____________
- ☐ Declined

MARITAL STATUS:

- ☐ Single
- ☐ Married
- ☐ Divorced/Separated
- ☐ Widow/Widower
- ☐ Declined

______________ ______________ ______________

Patients Preferred Pharmacy | Pharmacy Address | Pharmacy Phone

______________ ______________ ______________

Patient Employer | Employer Address | Employer Phone

Insurance Information

Primary Insurance: ______________________ Policy Number: ______________

Group Number: ______________ Insured (Guarantor) Name: ______________________

DOB: ____________ Last Four SSN: XXX-XX-________ Relationship to Patient: ______________

Secondary Insurance: ______________________ Policy Number: ______________

Group Number: ______________ Insured (Guarantor) Name: ______________________

DOB: ____________ Last Four SSN: XXX-XX-________ Relationship to Patient: ______________

Is this appointment related to an accident? Y N Are you retired from Rocky Flats? Y N

(If yes, please let receptionist know, you may be entitled to benefits)

Assignment and release: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered and/or not medically necessary services as determined by my insurance. I also authorize the physician to release any information required in the processing of this claim and future claims. I also hereby acknowledge that I have received or have been offered a copy of the practices Notice of Privacy Practice.

Patient or Legal Guardian Signature: ______________________________ Date: ______________

Patient Name: ____

Reason for Visit: ____ PCP: ________________________

Current Medications (Include Dosage): ☐ None

Medication	Dosage

Medication Allergies and Reaction: ____

____

____

Date of Your Last:

	Date		Date
AAA Screening		Hepatitis C Screening	
Bone Density (DEXA Scan)		PSA (blood test)	
Cervical Cancer Screening (Pap Smear)		Prostate Exam	
Colon Cancer Screening Type: ☐ Colonoscopy ☐ Cologuard ☐ FIT Test ☐ FOBT ☐ Sigmoidoscopy			
Hearing Exam		Vision Exam	

Vaccinations:

	Date		Date
Flu Shot		Prevnar 13	
Hepatitis A		Shingles	
Hepatitis B		Tetanus Shot	
HPV		Tetanus with Pertussis	
Meningitis		Covid -19	
Pneumovax			

Pediatric Vaccines: Please provide a copy of your child's immunization record.

Health History:

Have you ever had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis – Type: ________
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Bone Loss
- ☐ Cancer – Type: ________
- ☐ Cataracts
- ☐ Chest Pain
- ☐ Chronic Fatigue
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes – Type: ________
- ☐ Difficulty Hearing
- ☐ Diverticulitis
- ☐ Dizzy Spells
- ☐ Fibromyalgia
- ☐ Frequent Ear Infections
- ☐ Frequent Urinary Infections
- ☐ GERD (Heartburn)
- ☐ GI Bleed
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury/Concussion
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Arrhythmia/Palpitations
- ☐ Hemorrhoids
- ☐ Hepatitis – Type: ________
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Memory Loss
- ☐ MI (Heart Attack) – Date: ________
- ☐ Peripheral Artery Disease
- ☐ Pneumonia
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinusitis, recurrent
- ☐ Sleep Issues
- ☐ Stroke
- ☐ TB/Lung Disorder
- ☐ Thyroid Disorder
- ☐ Ulcers

Additional medical conditions your doctor should know about: ________________________________

____

____

Surgical History:

Surgery/Procedure	Year	Hospital/Location	Complications/Comments

Hospitalizations in The Past Year: ________________________________

____

____

Where do you go for bloodwork? ☐ Quest ☐ Labcorp ☐ Hospital ☐ Other: ________________

Do you have a Living Will? ☐ Yes ☐ No   Do you have a DNR? ☐ Yes ☐ No

Do you have a Medical Durable Power of Attorney? ☐ Yes ☐ No If yes, ________________ ________________

Please Print Name   Phone Number

Social History:

Tobacco – Smoking

☐ Never ☐ Former ☐ Current ☐ Passive Smoke Exposure

☐ Cigarettes ☐ Pipe ☐ Cigar

Start Date: ____________ Quit Date: ____________ #Years: ______ #Packs/Day: __________

Tobacco – Smokeless

☐ Never ☐ Former ☐ Current

Type: ☐ Snuff ☐ Chew

E-Cigarettes

☐ Never ☐ Former ☐ Current

Cartridges/Day: ________ Start Date: __________ Quit Date: __________

Alcohol

☐ Never ☐ Former

☐ Monthly or Less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week

Substance Abuse

☐ Never ☐ Former ☐ Current

Type: ______________________ How Often: __________________

Sexually Active

☐ Never ☐ Yes ☐ Not Currently

☐ Male Partners ☐ Female Partners

Type of Birth Control/Protection: ____

Diet (check all that apply)

☐ Well Balanced ☐ Diabetic ☐ Excessive Fat/Calories ☐ Vegetarian

☐ Weight Loss Products ☐ Vitamins/Herbals ☐ Routine Mealtimes ☐ Caffeine

Other: ____

Exercise

☐ No ☐ Yes

#days/week on average you engage in moderate to strenuous exercise? __________

#minutes you exercise per day on average: __________

Safety (check all that apply)

☐ CO detector in home ☐ Guns Unloaded/Locked ☐ Helmet Use ☐ Seat Belt Use

☐ Smoke detector in home ☐ Sunscreen Use ☐ Water Heater Temp Set ☐ Caffeine

With Whom Do You Live

☐ Alone ☐ Children ☐ Parent(s) ☐ Spouse/Partner

☐ Extended Family ☐ Other: ____________________________

Family History:

	Father	Mother	Brother	Sister	Son	Daughter	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
No Known Problems										
Alcohol Abuse										
Asthma										
Bleeding Disorder										
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Prostate Cancer										
Other Cancer(s)										
Dementia										
Diabetes										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Kidney Disease										
Liver Disease										
Lung Disease										
Mental Illness										
Stroke										
Thyroid Disease										

Father ☐ Alive ☐ Deceased – At what age: ____________

Mother ☐ Alive ☐ Deceased – At what age: ____________

Brother ☐ Alive ☐ Deceased – At what age: ____________

Sister ☐ Alive ☐ Deceased – At what age: ____________

Maternal Grandmother ☐ Alive ☐ Deceased – At what age: ____________

Maternal Grandfather ☐ Alive ☐ Deceased – At what age: ____________

Paternal Grandmother ☐ Alive ☐ Deceased – At what age: ____________

Paternal Grandfather ☐ Alive ☐ Deceased – At what age: ____________

Are you adopted? ☐ Yes ☐ No

Additional family history your doctor should know about: ____

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____

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