Center for Complementary Medicine

Patient Registration Form **Date:** / /

I. Patient Information

Name: ______ **Date of Birth:** / / **Sex:** M F

Address: ______

Phone: *Home* ( ) - *Work* ( ) - *Cell* ( ) -

Social Security Number: - - **Marital Status:** S M W D

Employer: ______ **Phone:** ( ) - **Occupation:** ______

Employer Address: ______

II. Responsible Party

☐ Check here if patient is over 18 and continue to Section III.

Relationship to Patient: ______

For minors, please list parent representing child for treatment.

Name: ______ **Date of Birth:** / / **Sex:** M F

Address: ______

Phone: *Home* ( ) - *Work* ( ) - *Cell* ( ) -

Social Security Number: - - **Marital Status:** S M W D

Employer: ______ **Phone:** ( ) - **Occupation:** ______

Employer Address: ______

III. Emergency Contact

Please list the person (who does not live with you) to notify in case of emergency.

Name: ______ **Relationship to Patient:** ______

Phone: *Home* ( ) - *Work* ( ) - *Cell* ( ) -

IV. Next of Kin

☐ Check here if next of kin is the same as the emergency contact.

Name: ______ **Relationship to Patient:** ______

Phone: *Home* ( ) - *Work* ( ) - *Cell* ( ) -

V. Insurance Information

Primary Insurance Provider: ______________________________

Member ID#: ______________________________

Claims Phone: *( ) -* ______ **Eligibility Phone:** *( ) -* ______

Claims Address: ______________________________

Subscriber Name: ______________ **Date of Birth:** / / ______ **Sex:** M F

Subscriber Address: ______________________________

Subscriber Employer: ______________ **Phone:** *( ) -* ______

Employer Address: ______________________________

Secondary Insurance Provider: ______________________________

Member ID#: ______________________________

Claims Phone: *( ) -* ______ **Eligibility Phone:** *( ) -* ______

Claims Address: ______________________________

Subscriber Name: ______________ **Date of Birth:** / / ______ **Sex:** M F

Subscriber Address: ______________________________

Subscriber Employer: ______________ **Phone:** *( ) -* ______

Employer Address: ______________________________

VI. Physician Information

Referred by: ______________________________

Do you have a primary care or family physician? Yes No

If yes: *Physician Name:* ______________ *Phone: ( ) -* ______

Health History

Patient is: Minor Adult **Age:**________ **Date of Birth:** ____/____/____ **Sex:** M F

Health History Completed by: *Name:* ______________________ *Relationship to Patient:* __________

Section I: Immunizations & TB Skin Testing

Yes (Year:_______) No **Tetanus / Diphtheria**
Yes (Year:_______) No **Measles / Mumps / Rubella**
Yes (Year:_______) No **Pneumonia Vaccine**
Yes (Year:_______) No **Polio**
Yes (Year:_______) No **Flu Vaccine**
Yes (Year:_______) No **Hepatitis B**
Yes (Year:_______) No **Chicken Pox**
Yes (Year:_______) No **TB Skin Test – If yes:** Positive Negative

Have you traveled outside of the U.S. in the last two years? Yes No **Where?** _____________

Section II: Past Medical History

Please circle yes or no if you have ever been diagnosed or treated for any of the following.

Yes No **Anemia**
Yes No **Allergies**
Yes No **Arthritis**
Yes No **Asthma**
Yes No **Bleeding Tendencies**
Yes No **Blood Clots**
Yes No **Bronchitis**
Yes No **Cancer**
Yes No **Cataracts**
Yes No **Chicken Pox**
Yes No **Diabetes / Sugar**
Yes No **Diphtheria**
Yes No **Emphysema**
Yes No **Glaucoma**
Yes No **Gout**
Yes No **Hay Fever**
Yes No **Heart Attack**
Yes No **Heart Disease**
Yes No **Hearing Problems**
Yes No **Hepatitis / Liver Disease**

Yes No **High Blood Pressure**
Yes No **Kidney Disease**
Yes No **Meningitis**
Yes No **Measles**
Yes No **Mumps**
Yes No **Neurological Problems**
Yes No **Pertussis (Whopping Cough)**
Yes No **Pneumonia**
Yes No **Polio**
Yes No **Psychiatric Problems**
Yes No **Prostate Problems**
Yes No **Rheumatic Fever**
Yes No **Rubella**
Yes No **Scarlet Fever**
Yes No **Seizure Disorder**
Yes No **Skin Problems / Acne**
Yes No **Stomach Problems / Ulcers**
Yes No **Stroke / CVA**
Yes No **Thyroid Problems**
Yes No **Tuberculosis**

Section III: Sexually Transmitted Diseases

Please circle yes or no if you have ever been diagnosed or treated for any of the following.

Yes No **Chlamydia**
Yes No **Gonorrhea**
Yes No **Herpes**
Yes No **HIV Positive**
Yes No **Syphilis**
Yes No **Venereal Warts**
Yes No **AIDS**

Section IV: Past Surgical History

Please list all surgeries you have had since birth; use back of page if necessary.

Surgery: ______________________ **Year:** ________

Surgery: ______________________ **Year:** ________

Surgery: ______________________ **Year:** ________

Surgery: ______________________ **Year:** ________

Surgery: ______________________ **Year:** ________

Section V: Current Medications

Please list all current medications including dosage (i.e., vitamins, birth control pills, over-the-counter meds, supplements, aspirin, oxygen, etc.).

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Section VI: Allergies

Please list all allergies to any medications, foods, or environmental substances. Explain the type of reaction you experienced and any treatment you received.

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Section VII: Social History & Habits

How many alcoholic beverages do you drink per day (include beer & wine)? ________________

Do you use street drugs (including cocaine, heroin or marijuana)? Yes No Substance:________

Please check if you use any of the following tobacco products:

☐ **Cigarettes** *Packs per day:* *Number of years:*

☐ **Pipe** *Hours per day:* *Number of years:*

☐ **Cigars** *Number per day:* *Number of years:*

☐ **Chewing Tobacco** ☐ **Snuff**

Have you quit smoking? Yes No **If yes, when:** ______________________________

Section VIII: Family Medical History

Please circle yes or no to indicate the medical history of your family members. Specify which relative had or has the condition (i.e., mother, father, brother, sister, grandparent, etc.).

Yes (_______)	No	**Anemia**	Yes (_______)	No	**Lung Disease**
Yes (_______)	No	**Blood Clots**	Yes (_______)	No	**Psychiatric Disorder**
Yes (_______)	No	**Cancer**	Yes (_______)	No	**Sickle Cell**
Yes (_______)	No	**Diabetes**	Yes (_______)	No	**Stroke**
Yes (_______)	No	**High Blood Pressure**	Yes (_______)	No	**Thyroid Problems**
Yes (_______)	No	**Heart Problems**	Yes (_______)	No	**Tuberculosis**

Other: ____

____

Family History

Mother:	*Age*	*Deceased*	*Cause*
Father :	*Age*	*Deceased*	*Cause*
Sister(s):	*Age*	*Deceased*	*Cause*
Brother(s):	*Age*	*Deceased*	*Cause*

Section IX: Additional History for Female Patients

Menstrual Cycle Information

Age at First Period: ______________ Age at Menopause: ______________

Are / were your periods regular? Yes No

Number of days between periods: ___________ Number of days of menstrual flow: ___________

Describe your menstrual flow (circle all that apply): Heavy Average Light Painful

Menopause Information

Any bleeding or spotting with menopause? Yes No Describe: __________________________

Ever taken hormones, shots or pills? Yes No Describe: __________________________

Past History

Had pain or discomfort with intercourse? Yes No Describe: __________________________

Had any bleeding or spotting after sex? Yes No Describe: __________________________

Had a urinary tract or bladder infection? Yes No Describe: __________________________

Had a vaginal infection? Yes (circle all that apply): Yeast Gardnerella Trichomonas None

Had an abnormal Pap smear? Yes No Describe: __________________________

If yes, what was done to your abnormal Pap?

Colposcopy (Date: ________) Freezing (Date: ________) Laser (Date: ________)

Birth Control

Please describe your current method of birth control, including name.

Birth Control Pills: ________________________ Diaphragm: ________________________

Intrauterine Device (IUD): __________________ Other: ________________________ None

Pregnancies

Please list all of your pregnancies and their outcome. Include year, length of pregnancy, vaginal or Caesarian delivery, miscarriage or abortion, and any complications. Use back of page if necessary.

1. ____
2. ____
3. ____
4. ____

Present Illness / Chief Complaint

Please circle yes or no if you are currently experiencing any of the following symptoms.

Yes No **Abdominal Pain**
Yes No **Back Pain**
Yes No **Blood in Nose**
Yes No **Blood in Stool / Bowel Problems**
Yes No **Blood in Urine**
Yes No **Breast Mass / Discharge**
Yes No **Chest Pain**
Yes No **Cough**
Yes No **Dizziness**
Yes No **Eyesight Changes**
Yes No **Fever / Chills**
Yes No **Hearing Problems**
Yes No **Heart Beating Fast**
Yes No **Loss of Consciousness**
Yes No **Nausea or Vomiting**
Yes No **Shortness of Breath**
Yes No **Vaginal Discharge, Burning, Itching**
Yes No **Wheezing**

Yes No **Weight Change; if yes, indicate change in pounds: _________ + / –**

Explain any "yes" answers, including the date it occurred:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Briefly explain what problem brought you to the Doctor today:

____

____

____

____

____

____

______________________________________ ______________________________________

Patient / Guardian Signature & Date ***Physician Signature & Date***