Patient Registration/Medical History

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Weight: _____ lbs. **Height:** _____ feet _____ inches

Preferred language: English Spanish German Other (specify) _____ **Ethnicity:** Hispanic/ Latino non-Hispanic/Latino (circle one)

Race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White (Circle One)

Date of injury _____ **Is the Injury work related?** _____

Are you or is there any chance that you might be pregnant? YES NO

Primary Care Physician: _____ **Phone:**_____

Cardiologist:_____ **Phone:**_____

Referred by:_____ **Phone:**_____

Please check any surgeries that you have had:

_____Cancer Surgery Type _____
_____Angioplasty
_____Bypass
_____ Cardiac Stents (heart)
_____Stents (other)
_____Tonsillectomy
_____Colon (Bowl Resection)
_____Thyroidectomy
_____Appendectomy
_____Gallbladder

_____Fem Pop Bypass RT leg LT leg
_____Carotid Endareterectomy RT LT
_____Cataract Removal RT LT
_____Plastic surgery Type_____
_____ Hysterectomy
_____Ovaries Removed
_____Hemorrhoidectomy
_____Tubal Ligation
_____Breast surgery mastectomy

_____Kidney Removed RT LT
_____Kidney Stone Removed
_____Prostate removed (prostatectomy)

_____T U R P
_____Colon (Bowl Resection)

____hernia repair type_____
_____Abdominal Aorta Aneurysm Repair

Please check any orthopedic surgeries:

_____Shoulder RT LT Type of surgery_____
_____Hip RT LT Type of surgery_____
_____Knee RT LT Type of surgery_____
_____Neck Type of surgery_____
_____Back Type of Surgery_____
_____Joint replacement / Part of body _____ RT LT

_____Hand RT LT Type of surgery_____
_____Foot RT LT Type of surgery_____
_____Arm RT LT Type of surgery_____
_____Leg RT LT Type of surgery_____
_____Wrist RT LT Type of surgery_____
_____Ankle RT LT Type of surgery_____

Do you have or have you been treated for any of the following:

_____Cancer/Type_____
_____Glaucoma RT LT
_____Macular Degeneration
_____Cataracts RT LT
_____Asthma
_____Tuberculosis
_____Environmental Allergies
_____COPD/Emphysema
_____Sleep Apnea/CPAP
_____CVA (Stroke)
_____TIA's
_____Parkinson's Disease
_____Seizures
_____Migraines

_____Fibromyalgia
_____ADD/ADHD
_____Alzheimer's/Dementia
_____Neuropathy
_____Diabetes
_____Thyroid disorder type_____
_____HIV +/Aids
_____Hepatitis A B C
_____History of MRSA
_____Colitis
_____Diverticulosis
_____GERD (reflux)
_____Hiatal Hernia
_____Irritable Bowel Syndrome

_____Ulcer/ Type_____
_____Congestive Heart Failure
_____Coronary Artery Disease
_____High Blood Pressure
_____Heart Attack
_____Pacemaker
_____Cardiac Stent/ Date____
_____ Stent (Other)/ Date_____
_____A-Fib
_____Defibrillator
_____Heart Arrhythmia/Type_____
_____High Cholesterol
_____High Triglycerides
_____MVP

_____Osteoarthritis
_____Osteoporosis/Osteopenia
_____Rheumatoid Arthritis
_____Gout
_____Kidney Stone
_____BHP(enlarged prostate)
_____Urinary Tract Infections
_____DVT (blood clot)
_____Carotid Artery Disease
_____Blood Disorder/Type_____
_____Depression
_____Anemia/Bleeding Disorder
_____Psoriasis
_____Eczema

_____Other medical conditions_____

SOCIAL HISTORY

Do you currently or have you ever used tobacco products? YES NO

If **YES**, What type? Cigarette Chewing tobacco/snuff E-cigarette Amount used daily?_____

If **NO** have you ever used tobacco products? YES NO Date you stopped using tobacco products?_____

Do you consume alcoholic beverages? YES NO Number of drinks daily?_____ Do you have a history of alcoholism? YES NO

Do you use recreational drugs? YES NO

Patient Registration/Medical History

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

FAMILY MEDICAL HISTORY

	Date of Birth	Alive	Date of Death
FATHER	_____	Yes No	_____

	Approximate age diagnosed
COPD	_____
Diabetes	_____
Cancer	_____
Heart Disease	_____
Stroke	_____

	Date of Birth	Alive	Date of Death
MOTHER	_____	Yes No	_____

	Approximate age diagnosed
COPD	_____
Diabetes	_____
Cancer	_____
Heart Disease	_____
Stroke	_____

MEDICATIONS

List all medications**, prescription** and **over the counter,** are you currently taking?

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES

Do you have any medication allergies? YES NO

Do you have an allergy to Latex? YES NO Date tested? _____

Medication Allergies

Medication _____ **Reaction** _____

Medication _____ **Reaction** _____

Medication _____ **Reaction** _____