Scottsdale Family Health

Established Patient- Medical Registration Form

Patient Name: _____ Date of Birth:_____ Today's Date _____

PHARMACY: (Please list name and number of pharmacy you wish to have prescriptions sent to.)

Pharmacy _____ Pharmacy Number _____

MEDICAL HISTORY : (Check any condition you have or have had in the past.)

- o Abnormal Heart Rhythm (tachycardia, atrial fibrillation, flutter, etc)
- o Allergies
- o Anxiety
- o Asthma
- o Arthritis
- o Back Pain
- o Cancer
  If yes, list what kind(s)_____
- o Cholesterol Disorder
- o Depression
- o Diabetes
- o Fainting/Dizzy Spells
- o Fatigue
- o Gastritis/Stomach Ulcer/Stomach Problems
- o Headaches
- o Blood Pressure Problem
  If yes, circle if High or Low
- o Kidney Failure
- o Lung Disease
- o Liver Disease
- o Pleurisy
- o Psychiatric Illness
  If yes, please describe_____
- o Rheumatic Fever
- o Gastrointestinal (GI) Disorder
  If yes, please describe_____
- o Strokes or Transient Ischemic Attacks (TIA)
- o Thyroid Disease
- o Tuberculosis
- o Vision Disorder
- o Weight Fluctuations

Please list any other medical problems you may have that was not listed above:

Have you ever had any of the following:

- o Alcoholism
- o Drug Dependency
- o Transfusions

Have you had any of the following: Sexually Transmitted Diseases (STD) and other infection (check any that apply):

- o Gonorrhea
- o HIV/AIDS
- o Genital Warts
- o Abnormal PAP Smear
- o Chlamydia
- o Genital Herpes
- o Trichomonas

SURGICAL HISTORY

List any surgeries you have had and the approximate date (e.g. hernia, appendectomy, gallbladder, wisdom tooth extractions, C-Section, etc)

Surgery	Approximate Date or Number of Years Ago

OTHER PROVIDERS :

Please List Other Doctors/Providers You See.

Doctor/Provider Name	Specialties

CURRENT MEDICATIONS

Please list the name, dosage, and how often taken. Include inhalers and nasal sprays, etc.

[OK TO ATTACH LIST]

Medication Name	Dosage	Times per day

List any medications that were recently stopped and reason why the medicine was stopped:

_____

_____

DIETARY SUPPLEMENTS, HERBS, VITAMINS:

Please list name, dosage, and how often taken. [OK TO ATTACH LIST]

Name	Dosage	Times per day

ALLERGIES:

List any **medications or food** that has caused a bad reaction or allergy in the past.

Medication/Food	What happened with exposure

FAMILY HISTORY

Please list any medical conditions that run in the family (e.g. thyroid disease, diabetes, high blood pressure, alcoholism, depression, cancer, etc)

Family Member	Medical Conditions
Mother	
Father	
Sibling(s)	
Children	

Other family members:_____

SOCIAL HISTORY:

1) What is your current profession? _____
2) Have you ever held an occupation that put you at risk for any medical problems: Yes or No
   If yes, please describe: _____
3) Are you currently married? YES NO
4) Do you have any children? YES NO
   If yes, please state their names and ages:

5) Have you ever smoked?
   If Yes,
   a) Do you still smoke? YES NO
   b) For how many years did/do you smoke? _____
   c) On average, how many cigarettes do you smoke per day?_____

6) Have you used any other tobacco products?
   If yes, what types _____

7) Do you exercise? YES NO
   If yes, what type or form of exercise _____
   If yes, how many days a week and hours per day _____

8) Do you consume alcohol?
   If yes, how many drinks? _____ per day/week/month (circle appropriate)
   If yes, what type? _____

9) Do you feel that you have any risk factors for Sexually Transmitted Disease (multiple partners, unprotected intercourse, cheating partner, etc) : YES NO

Current activity level (check which describes most accurately):

__Not much (sedentary) __Minimal __Active, but No Exercise __Some Exercise

__Regular Exercise :_____

Please describe your current diet (check all that apply):

__ Well-balanced, controlled portions ___ Unbalanced ___ Excessive Portions

__ Low Salt __ Low Fat ___ Low Carbs _____ Restricted calories (_____ cal/day)

___ Other: _____

End of Life Planning

Do you have a written advance directive, living will, power of attorney, or end of life planning (such as resuscitation desire)? ___Yes ___No

If yes, is this in your chart? ___Yes ___No ___Unsure

Do you wish to discuss any end of life issues with your doctor? ___Yes ___No

	Yes	No
In the last 2 weeks have you felt depressed?		
Have you dropped any of your hobbies/interests?		
Do you prefer to stay at home rather than going out?		
Are you having significant trouble with your memory?		
Do you feel sad most of the time?		
	Yes	No
Do you feel you have any significant memory problems?		
Have you forgotten what you had for dinner yesterday?		
Do you have to keep lists so you don't forget things?		
Do you frequently lose things at home or at work?		
Have you ever gotten lost while driving?		
Have you ever forgotten why you are at a store or other place?		
Have you had trouble balancing your checkbook lately?		
Do people often accuse you of repeating yourself?		
	Yes	No
Do you feel you have any significant safety concerns?		
Do you have any trouble seeing?		
Do you have any trouble speaking?		
Do you have any trouble hearing?		
Do you have any trouble bathing?		
Do you have any trouble dressing?		
Do you have any trouble eating?		

	Yes	No
Do you feel unstable or unsteady when standing?		
Do you have any trouble using stairs, if you have them?		
Have you fallen or almost fallen in the last 60 days?		
Do you know of any fire hazards in your home?		
Would you have any trouble getting 911 help if needed?		

ETHNICITY:

- o Caucasian
- o African American
- o Native American
- o Asian
- o Hispanic
- o Middle Eastern
- o Multi-ethnic
- o Other _____

HEALTHCARE MAINTENANCE:

1) When was your last physical exam? _____
2) When was the last time you had screening labs? _____
3) When was your last tetanus immunization? _____
4) Have you had the pneumonia vaccine? YES, when _____ NO
5) Have you had the influenza vaccine? YES , when _____ NO
6) Have you had a shingles vaccine? YES , when _____ NO
7) Have you had a screening colonoscopy? YES, when _____ NO
8) When was your last EKG? _____
9) Have you had a cardiac stress test? YES, when _____ NO
10) When was your last eye exam? _____

FOR FEMALE PATIENTS ONLY:

1) Are you pregnant? YES , how many weeks/months _____ NO
2) How many times have you been pregnant? _____
3) How many live births? _____
4) Date of last mammogram _____
5) Date of your last period _____
6) Date of last PAP Smear _____
7) Last bone scan _____

FOR MALE PATIENTS ONLY:

1) Date of last Rectal/Prostate Exam _____
2) Last PSA lab _____