HONORHEALTH

Medical Group

# New Patient Registration – Medical Information

Patient Name: First_____Middle_____Last_____

Date of Birth: _____/_____/_____

| Who are your current medical providers? | |
|---|---|
| Provider name | Specialty, or condition for which they treat you |
| | |
| | |
| | |

| Preventive Care | | | | | |
|---|---|---|---|---|---|
| | Date | | Date | | Date |
| Annual physical | | Prostate screen | | Cholesterol test | |
| Colonoscopy | | Pap screen | | Diabetes screen | |
| Bone density | | Mammogram | | Eye exam | |
| Dental exam | | | | | |

| Immunizations | | | | | |
|---|---|---|---|---|---|
| | Date | | Date | | Date |
| Tetanus (Td or Tdap) | | HPV (Gardasil) | | Influenza (flu) | |
| Hepatitis A | | Hepatitis B | | Meningitis | |
| Pneumonia | | Shingles | | Other (please write below) | |
| | | | | | |

| Allergies or intolerances to medications? | |
|---|---|
| Name | Reaction |
| | |
| | |
| | |

| Please list all medications, supplements, over the counter drugs, creams and inhalers. | | |
|---|---|---|
| Name | Dose/Strength | Frequency taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Name: First_____ Middle _____Last_____ Date of Birth: ____/____/_____

| Please circle all current or past medical problems or conditions. | | |
|---|---|---|
| Heart Failure | High Blood Pressure | ADD/ADHD |
| Chronic Lung Disease | Hyperthyroidism | Seasonal Allergies |
| Heart Artery Disease | Hypothyroidism | Anemia |
| Depression | Kidney Disease | Anxiety |
| Diabetes Type 1 | Migraines | Arthritis |
| Diabetes Type 2 | Heart Attack | Asthma |
| Emphysema | Stomach/Intestine Ulcers | Bipolar Disorder |
| Heartburn | Seizures | Blood Clots |
| Glaucoma | Sexually Transmitted Infection | Blood Transfusion |
| Heart Murmur | Stroke | Cancer |
| HIV/AIDS | Substance Abuse | Cataracts |
| High Cholesterol | Valley Fever | |
| | | |

| Please circle all major operations or surgeries. | | |
|---|---|---|
| None | Colon | Joint Replacement |
| Appendectomy | Coronary Artery Stent | Spine |
| Breast Augmentation | Cosmetic Surgery | Thyroid Surgery |
| Breast Surgery | Eye | Tonsillectomy |
| Cesarean Section | Fracture Repair | Tubes Tied |
| Heart Bypass | Hernia repair | Heart Valve surgery |
| Gallbladder | Hysterectomy | Ovaries |
| | | |

**Family Medical History – Please check the appropriate box if a condition is/was present.**

| | Alcohol Abuse | Arthritis | Asthma | Birth Defects | Cancer | COPD | Depression | Diabetes | Drug Abuse | Early Death | Hearing Loss | High Cholesterol | High Blood Press | Kidney Disease | Mental Illness | Miscarriages | Stroke | Vision Loss | Alzheimer's | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | | | | | | | |
| Siblings | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Children | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | | |

Patient Name: First_____ Middle _____Last_____ Date of Birth: ____/____/_____

| **Social History** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Alcohol Use – Please circle your response.** | | | | | | | | | | | |
| Glasses of wine per week | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10+ |
| Cans of beer per week | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10+ |
| Shots of liquor per week | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10+ |
| Mixed drinks with 0.5 ounces alcohol per week | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10+ |

**Sexual Activity – Please check your response.**

Sexually active? ☐ Currently ☐ Never ☐ Not Currently

Sexual Partners? ☐ Men ☐ Women ☐ Both

Birth control used? ☐ Pulling out ☐ Condom ☐ Diaphragm ☐ Implant ☐ Inserts ☐ IUD
☐ The Pill ☐ Patch ☐ Rhythm ☐ Spermicide
☐ Sponge ☐ Surgical ☐ Not applicable

**Drug Use – Please check your response.**

☐ None ☐ Amphetamines ☐ Benzodiazepines ☐ "Crack" Cocaine ☐ Cocaine
☐ Heroin ☐ Marijuana ☐ Methamphetamines ☐ PCP ☐ Huff Gasses

**Tobacco Use – Please check your response.**

☐ Smoke every day ☐ Smoke some days ☐ Former smoker ☐ Heavy smoker
☐ Light smoker ☐ Never smoked ☐ Second-hand exposure

If ever smoked, how many packs/day average?
☐ ½ ☐ 1 ☐ 1½ ☐ 2 ☐ 3 or more
How many years smoked?

You ever chewed? ☐ Yes ☐ No

If you currently use any tobacco product, are you ready to quit? ☐ Yes ☐ No

| **Hospitalizations** | | |
|---|---|---|
| Reason | Year | Comments |
| | | |
| | | |
| | | |
| | | |

| **Major Injuries** | | |
|---|---|---|
| Type | Year | Comments |
| | | |
| | | |
| | | |
| | | |