Annapolis Family Medicine

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	E-mail Address:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Cell phone no.: ( )	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PREFERRED PHARMACY

Name:	Location:	
	Phone:	Fax:

CURRENT MEDICAL PROBLEMS

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ALLERGIES

Allergy	Reaction

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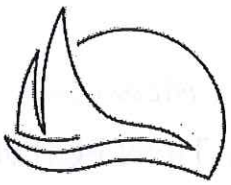
CURRENT MEDICATION LIST

Name	Strength	Direction	Prescribed by

PAST MEDICAL HISTORY

Childhood Illnesses			
Chronic Illnesses			
Last Eye Exam:		Last Dental Exam	
Accidents (with dates):			
Surgeries/Procedures (with dates):			
Other Hospital Stays (with dates):			
Any problems with anesthesia? ☐ Yes ☐ No	If yes, explain:		

Specialists you currently see:	Name	Specialty



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FAMILY HISTORY

Family Member	Medical Issues	Age
Father		
Mother		
Siblings		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		

SOCIAL HISTORY

Do you drink alcohol?	❑ Yes ❑No	If yes, how much?
Are you sexually active?	❑ Yes ❑ No	If yes, what form of contraception do you use?
Do you consume caffeine?	❑ Yes ❑ No	If yes, how much?
Diet: ❑ Balanced ❑ Vegetarian ❑Diabetic ❑ Low Salt ❑ Low Fat ❑ Low Carb ❑ Other _____		
Have you ever been in an abusive relationship?	❑ Yes ❑ No	
Are you afraid of your partner?	❑ Yes ❑ No	
Education: ❑ High School ❑ Some College ❑ College Degree ❑ Trade School ❑ Other: _____		
Do you do some form of exercise daily?	❑ Yes ❑ No	If yes, how much?
Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____		
Place of Birth (City, State)		
Have you lived abroad for more than one month?	❑ Yes ❑ No	
Do you wear seatbelts?	❑ Yes ❑ No	
Do you smoke or chew tobacco?	❑ Yes ❑ No	If yes, how much?
Do you use recreational drugs?	❑ Yes ❑ No	If yes, what kind?

WOMEN'S HEALTH

Date of last menstrual period:	Typical duration (in days):	# of Total Pregnancies:
Are periods regular? ❑ Yes ❑ No		# of Full Term Births:
Flow: ❑ Normal ❑ Light ❑ Heavy ❑ Other: _____		# of Premature Births:
How many days apart are periods?		# of Abortions- induced:
Age at onset of period:		# of Miscarriages:
Age at cessation of periods:		# of Ectopic Pregnancies:
Have you ever had any abnormal pap smears?		# of Multiple Birth Pregnancies:
Have you ever been diagnosed with any STD's?		# of Living Children:

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HEALTH MAINTENANCE			
Hep A		Breast Exam	
Hep B		Cardiac Stress Test	
Flu Vaccine		Colonoscopy	
Pneumonia Vaccine		EKG	
Tuberculosis Test		Hearing Exam	
Positive PPD		Mammogram	
TdaP (Tetanus, Diptheria and Pertussis)		Eye Exam	
Meningococcal		Pelvis Exam	
MMR		Pap Smear/GYN	
Zostavax		Physical Exam	
Bone Density Scan		Prostate Exam	

REVIEW OF SYMPTOMS

Check all that apply.

Skin
☐ Skin diseases

Eyes
☐ Eye diseases

ENT
☐ Hay Fever
☐ Head or Neck

Respiratory
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Persistent cough

Cardiovascular
☐ High blood pressure
☐ Heart disease
☐ Chest pain
☐ Swollen ankles
☐ Palpitations
☐ Lightheadedness

Neurological
☐ Headache

Gastrointestinal
☐ Abdominal discomfort
☐ Indigestion
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Blood in stool
☐ Ulcers
☐ Change in bowel habits
☐ Unexplained weight gain/loss
☐ Hemorrhoids
☐ Gall bladder disease
☐ Colitis

Genitourinary (Female)
☐ Frequent urination
☐ Kidney diseases
☐ Kidney stones
☐ Difficulty urinating

Genitourinary (Male)
☐ Frequent urination
☐ Kidney diseases
☐ Kidney stones
☐ Difficulty urinating

Musculoskeletal
☐ Arthritis
☐ Low back problems
☐ Gout

Psychiatric
☐ Anxiety
☐ Depression
☐ Alcohol abuse
☐ Drug abuse

Hematologic/Oncologic
☐ Cancer(s)
☐ Blood disorders
☐ Anemia

Infectious Disease
☐ Venereal diseases
☐ Hepatitis or Jaundice
☐ TB
☐ Rheumatic fever

Endocrine
☐ Diabetes
☐ Thyroid disease

OTHER

Do you have an advanced directive or living will?	☐ Yes ☐ No
Notes:	

Authorized Signature:	Date:
Reviewed by:	Date: