## PATIENT REGISTRATION

DATE _____

PATIENT'S NAME _____ BIRTH DATE _____ SINGLE ___ WIDOWED ___

NAME OF SPOUSE _____ BIRTH DATE _____ MARRIED ___ DIVORCED ___

IF A CHILD, PARENT'S NAME _____ SEPARATED ___

STREET ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

PATIENT EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

PURPOSE OF THIS APPOINTMENT _____

IN CASE OF EMERGENCY, WHOM SHOULD BE NOTIFIED _____ PHONE _____

WHO WILL PAY THIS ACCOUNT _____

PATIENT'S SOCIAL SECURITY NUMBER _____

SPOUSE'S SOCIAL SECURITY NUMBER _____

IF USING CHARGE CARD, NAME _____ CARD NO. _____

IF WELFARE, YOUR NUMBER _____ COUNTY OF _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES YES _____ NO _____

IF SO, NAME OF COMPANY _____ POLICY NO. _____

IS POLICY CONNECTED WITH YOUR UNION YES ___ NO ___ IF YES, NAME OF UNION _____

LOCAL NO. _____ GROUP NO. _____

IF INSURANCE COVERED, SOCIAL SECURITY NO. OF PERSON COVERED _____

(IT IS NECESSARY THAT YOU PROVIDE CLAIM FORMS FOR ALL PROFESSIONAL SERVICES THAT MAY BE ELIGIBLE FOR INSURANCE COVERAGE)

WHOM MAY WE THANK FOR REFERRING YOU _____

COMMENTS: _____

_____

_____

_____

_____

I HAVE REVIEWED BOTH SIDES OF THIS DOCUMENT AND THERE HAVE BEEN NO CHANGES.

| FORM DATE | TODAY'S DATE | SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

# PATIENT REGISTRATION / HEALTH HISTORY

# HEALTH QUESTIONNAIRE

NAME _____ REGISTRATION NO. _____

Indicate your correct answer to each question by placing an "X" in either the "Yes", "No", or "Don't Know" column. Please answer all questions. Answers to the following questions are for our records only and will be considered confidential.

Name of your primary physician _____ Phone _____ May we request your health record? Yes ☐ No ☐

Physicians Address _____

| | Yes | No | Don't Know |
|---|---|---|---|
| Have you been examined and/or treated by a physician within the last year? | | | |
| Are you taking medicines now? | | | |
| What? _____ | | | |
| Have you been: | | | |
| 1. Seriously ill_____If yes, what?_____ | | | |
| 2. Hospitalized?_____If yes, what?_____ | | | |
| 3. Treated with X-ray, cobalt for tumors What area(s)_____ | | | |
| 4. Told you have a heart murmur_____ | | | |
| Have you had: | | | |
| 5. Major Surgery_____If yes, what?_____ | | | |
| 6. Blood transfusion _____ | | | |
| 7. Rheumatic fever _____ | | | |
| 8. Inflammatory rheumatism _____ | | | |
| 9. Yellow jaundice _____ | | | |
| 10. Tuberculosis _____ | | | |
| 11. Venereal disease _____ | | | |
| 12. Heart attack _____ | | | |
| 13. Stroke _____ | | | |
| 14. Hives, skin rash _____ | | | |
| 15. Asthma, Hay fever _____ | | | |
| 16. Cancer _____ | | | |
| 17. Diabetes (Sugar disease) _____ | | | |
| 18. Injury to face or jaw _____ | | | |
| 18.a Hepatitis _____ | | | |
| Have you had unusual reaction to any of these medicines: | | | |
| 19. Dental anesthesia _____ | | | |
| 20. Aspirin _____ | | | |
| 21. Penicillin _____ | | | |
| 22. Iodine _____ | | | |
| 23. Sleeping Pills_____ | | | |
| 24. Other: _____ | | | |
| **Hematology:** | | | |
| **Do you:** | | | |
| **25. Bleed a long time after an injury?** _____ | | | |
| **26. Bruise easily?** _____ | | | |
| **27. Have blood disorders, anemia, thin blood** _____ | | | |
| **27.a Have you tested positive to the HIV virus?**_____ | | | |
| Head: | | | |
| Do you have: | | | |
| 28. Severe headaches _____ | | | |
| 29. Eye troubles _____ | | | |
| 30. Frequent colds _____ | | | |
| 31. Sinus trouble_____ | | | |
| 32. Frequent nosebleeds _____ | | | |
| 33. Sore throats _____ | | | |
| 34. Sensitive teeth _____ | | | |
| 35. Aching teeth _____ | | | |
| 36. Bleeding gums _____ | | | |
| 37. Sore gums or mouth _____ | | | |
| 38. Frequent canker sores, fever blisters, | | | |
| 39. Sore jaw muscles _____ | | | |
| 40. Earaches _____ | | | |
| 41. Difficulty upon opening mouth wide _____ | | | |

| | Yes | No | Don't Know |
|---|---|---|---|
| Cardiorespiratory | | | |
| Do you have: | | | |
| 42. High blood pressure _____ | | | |
| 42.a A pacemaker _____ | | | |
| 43. Shortness of breath _____ | | | |
| 44. Chest pains _____ | | | |
| 45. Swollen ankles _____ | | | |
| 46. Persistent Cough _____ | | | |
| 47. Blood sputum produced by coughing _____ | | | |
| Gastrointestinal: | | | |
| Have you had: | | | |
| 48. Recent change of appetite _____ | | | |
| 49. Foods that you cannot eat _____ | | | |
| 50. Difficulty in swallowing _____ | | | |
| 51. Frequent indigestion _____ | | | |
| 52. Frequent vomiting_____ | | | |
| 52.a An ulcer _____ | | | |
| Genitourinary: | | | |
| Do you: | | | |
| 53. Feel thirsty much of the time _____ | | | |
| 54. Urinate more than six times a day _____ | | | |
| 55. Have kidney trouble _____ | | | |
| Neuromuscular-Skeletal: | | | |
| Do you have: | | | |
| 56. Painful, swollen joints _____ | | | |
| 57. Numb or prickling sensations on your skin _____ | | | |
| 58. A history of broken bones _____ | | | |
| 59. A tendency to faint _____ | | | |
| 60. Fits or convulsions _____ | | | |
| Endocrine-Metabolic: | | | |
| Do you: | | | |
| 61. Get tired easily _____ | | | |
| 62. Feel excessively nervous_____ | | | |
| 63. Feel more discomfort in hot weather than most other people _____ | | | |
| Habits: | | | |
| Do you consistently use: | | | |
| 64. Tobacco_____ | | | |
| 65. Alcoholic beverages _____ | | | |
| 66. Drugs: _____ | | | |
| 67. Other medicines: _____ | | | |
| **Women Only:** | | | |
| Are: | | | |
| 68. You now pregnant _____ (How many months _____ ) | | | |
| 69. You past menopause _____ | | | |
| 70. Your menstrual periods irregular _____ | | | |
| **Children Only:** | | | |
| Is the child: | | | |
| 71. A bed wetter_____ | | | |
| 72. Experiencing trouble in school _____ | | | |
| 73. A slow learner _____ | | | |
| 74. Has the child experienced an unfavorable reaction from medical or dental treatment _____ | | | |
| 75. Number of days missed from school last year _____ | | | |

Patient's Signature or, if a Minor, Signature of Parent or legal Guardian Date