

Patient Registration

Name: _____ Date of Birth: ____/____/____
Telephone: (____) ____ - ____ Social Security #: _____
Home Address: _____ Drivers License#: _____
City: _____ State: _____ Zip Code: _____
Marital Status: Single Married Divorced Widow/er Minor
Employer: _____ Telephone (____) ____ - ____
Address _____ Occupation _____

Financial Responsibility

Name: _____ Date of Birth: ____/____/____
Telephone: (____) ____ - ____ Social Security #: _____
Home Address: _____ Drivers License#: _____
City: _____ State: _____ Zip Code: _____

Person to Contact in an Emergency

Name: _____ Relationship _____
Home Address: _____ Telephone (____) ____ - ____
City: _____ State: _____ Zip Code: _____

Primary Insurance *You must fill in this information. A copy of your insurance card is not adequate.*

Insurance Company Name: _____ Effective Date: ____/____/____
Home Address: _____ Telephone: (____) ____ - ____
City: _____ State: _____ Zip Code: _____
Policy Holders Name: _____ Date of Birth: ____/____/____
Policy/Certificate Number: _____ Group Number: _____

Secondary Insurance *You must fill in this information. A copy of your insurance card is not adequate.*

Insurance Company Name: _____ Effective Date: ____/____/____
Home Address: _____ Telephone: (____) ____ - ____
City: _____ State: _____ Zip Code: _____
Policy Holders Name: _____ Date of Birth: ____/____/____
Policy/Certificate Number: _____ Group Number: _____

Assignment of Benefits: I authorize the release of any medical or other information necessary to process this claim. This information may also be released to the physician referring me for care to Dr. Linfoot. I also request that payment of benefits be paid directly to Peter A. Linfoot, PhD., M.D. I have read, understand and agree to the financial policies of this office, a copy of which has been provided to me. I agree to pay \$30 if I do not cancel my appointment by 12:00 noon on the day prior to my scheduled appointment.

Patient Signature _____ Date: ____/____/____

Last Name _____ First Name _____
Date of Birth ____/____/____ Male Female Referred by _____

List all **Prescription Medications** you are currently taking.

Medication	Dosage	Frequency
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____
9 _____	_____	_____
10 _____	_____	_____

List all **Supplements** and **Non Prescription Medications** you are currently taking.

1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

Do you have any Drug Allergies? Yes No

If Yes, please list allergies below and the type of reaction.

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____

Prior Medical Illnesses Hospitalizations & Surgeries

Please indicate medical diagnosis or reason for hospitalization or surgical procedure.

1 _____	Date _____	Doctor _____
2 _____	Date _____	Doctor _____
3 _____	Date _____	Doctor _____
4 _____	Date _____	Doctor _____
5 _____	Date _____	Doctor _____

Family History

Use the following code. Please indicate the age of diagnosis in parentheses.

- | | |
|-------------|----------------------------|
| M - Mother | PGF - Paternal Grandfather |
| F - Father | PGM - Paternal Grandmother |
| B - Brother | MGF - Maternal Grandfather |
| S - Sister | MGM - Maternal Grandmother |

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Adrenal Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pituitary Tumor | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Calcium | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Kidney or Bladder Stones |

Social History

Have you ever smoked? No Yes Packs/day _____ # of years _____ Date Quit _____

Do you drink Alcohol? No Yes Drinks/day _____ Type _____

Do you drink caffinated beverages? (coffee, tea, soft drinks?) No Yes How many/day _____

Have you ever used recreational drugs? No Yes
Drug used _____ How often _____

Do you exercrise regularly?

No Yes Aerobic? No Yes Number of times a week? _____

Review of Systems

Please check any of the following symptoms that are currently bothering you or have been a problem in the past

Head/Ears/Eyes Nose/Throat/Mouth

- Ear aches
- Ringing in the ears
- Decreased hearing
- Ear infections
- Blurred vision
- Double vision
- Frequent sinusitis
- Frequent nose bleeds
- Mouth sores

Musculoskeletal

- Decreased muscle strength
- Sciatica
- Joint stiffness
- Joint pain

Cardiovascular

- History of heart attack
- Tightness or pressure in chest
- Discomfort in
 jaw, neck or left arm
- Discomfort when exercising
- Murmors
- Palipatations
- Swelling of feet
- High blood pressure
- Fainting
- Rheumatic fever

Pulmonary

- Chronic cough
- Shortness of breath
- Asthma
- Coughing up blood
- Tuberculosis
- Pnemonia
- Frequent bronchitis

Genitourinary

- Blood in Urine
- Pain with urination
- Frequent urination at night
- Kidney stones
- Frequent urinary
 tract infections
- Flank pain
- Incontinence
- Weak size and force of stream

Lymphatics

- History of swollen lymph nodes
- Disease of lymphatics

Skin

- Rashes
- Abnormal moles
- Eczema
- Vitiligo
- Excesive bruising

Constitutional

- Loss of conciousness
- Seizures
- Numbness
- Tingling
- Loss of coordination

Gastrointestinal

- Abdominal pain
- Constipation
- Nausea
- Vomiting
- Blood in stool
- Frequent indigestion
- Gall bladder disease

Endocrine

- Heat intolerance
- Cold intolerance
- Frequent urination
- Weight changes
- Diabetes
- Thyroid disorder

Women Only

Menstrual History:

Age at onset: _____ Heavy Medium Light
Regular Yes No Pains or Cramps Yes No
Cycle _____ (from start to end) Date of last cycle: _____
Last duration of menses: _____ days.

Which have you experienced in the past 6 months?

- Decreased interest in sex Vaginal dryness or pain during intercourse
 Decreased sexual satisfaction Hot flashes or sweats

Are you currently:

- Having regular menstrual periods? On birth control pills? Using an IUD?
 Having irregular or abnormal periods Post total hysterectomy Post partial hysterectomy
Pregnant

How many pregnancies have you had? _____ How many deliveries have you had? _____

How many spontaneous abortions (miscarriages) have you had? _____

How many therapeutic abortions have you had? _____

How many infants weighed more than 9 pounds at birth? _____

Which of these complications have you had?

- Bladder or Kidney Infection Toxemia Albumin (protein) in urine
 Hypertension Diabetes only during pregnancy
 Other _____

Estimate as accurately as possible:

Current weight: _____

Weight one year ago: _____

Maximun weight: _____ Age: _____

At present my health is such that:

I cannot do my usual work at all

I can work but limited amount and time

I am not limited in any way

Have you ever been disabled? Yes No

List your current problems or complaints:

Are there any specific things you would like to discuss or would like to have a nexplanation of?
If yes, please write them down so we do not overlook them.
