NEW PATIENT REGISTRATION

DATE: ___________________________

NAME: ____DOB:_____________ SEX: _________

MAILING ADDRESS:____

CITY, STATE, ZIP CODE: ____

SSN: __________________________ EMPLOYER:_____________________ MINOR: YES OR NO

CONTACT #: ___________________________ EMAIL:__________________________________

MAY WE LEAVE A MESSAGE?: YES OR NO

DRIVERS LICENSE #:____ STATE:_____________

MEDICAL/REFERRAL INFORMATION

PRIMARY CARE PROVIDER:__________________________ PHONE #: _____________________

REFERRING PHYSICIAN: _____________________________ PHONE #: _____________________

PHARMACY: ______________________________________ PHONE #: _____________________

PRIMARY EMERGENCY CONTACT

NAME: _______________________ RELATIONSHIP TO PATIENT: _______________________

PHONE #: ___________________________

HOW DID YOU HEAR ABOUT US?

____

____

____

SIGNATURE OF PATIENT/GUARDIAN PRINTED NAME DATE

PATIENT MEDICAL HISTORY

DATE: ______________________

PATIENT NAME:____________________________________ AGE: _________ DOB:____________________________

PHONE:____________________________________ SECONDARY PHONE:____________________________________

EMAIL:____

EMERGENCY CONTACT:______________________________ EMERGENCY CONTACT PHONE: ____________________

CURRENT PSYCHIATRIC DIAGNOSIS: ____

PSYCHIATRIC/MEDICAL HOSPITALIZATIONS & RELATED DIAGNOSIS:

____

HEIGHT: ____ WEIGHT: ____

CURRENT MEDICATIONS (Please list all medications, supplements, or herbs taken currently):

MEDICATION	DOSE/FREQUENCY	MEDICATION	DOSE/FREQUENCY

ALLERGIES:____

PREVIOUS SURGERIES:

SURGERY	DATE OF SURGERY (if known)

PRIOR ANESTHESIA COMPLICATIONS?: YES OR NO

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS?: YES OR NO
(If YES, please explain): ____

SOCIAL HISTORY:

OCCUPATION: _________________________________ PLEASE CIRCLE: SINGLE/MARRIED/DIVORCED/WIDOWED

SUBSTANCE USE:	HOW MUCH?	HOW LONG?	LAST USE?
TOBACCO			

ALCOHOL			
MARIJUANA			
COCAINE			
HEROIN			
OTHER:			

MEDICAL HISTORY (Please check all that apply):

	ASTHMA		ACID REFLUX		FATIGUE
	COPD/EMPHYSEMA/BRONCHITIS		CIRRHOSIS/LIVER PROBLEMS		WEIGHT LOSS/GAIN
	SLEEP APNEA		BOWEL PROBLEMS		HOT FLASHES
	SHORTNESS OF BREATH		SEIZURES		BACK PAIN
	CORONARY ARTERY DISEASE		STROKE OR TIA		JOINT PAIN
	PRIOR HEART ATTACK		BRAIN ANEURYSM		INSOMNIA
	CHEST PAIN		BLURRED VISION OR VISION PROBLEMS		MOOD CHANGE
	CONGESTIVE HEART FAILURE (CHF)		HYPOTHYROID		ANXIETY/NERVOUSNESS
	DYSRHYTHMIAS (irregular heart rhythms)		HYPERTHYROID		DEPRESSION
	PACEMAKER/ICD		HEADACHE/MIGRAINE		MEMORY LOSS
	HIGH BLOOD PRESSURE		URINARY PROBLEMS		BIPOLAR DISEASE
	HIGH CHOLESTEROL		KIDNEY PROBLEMS		SCHIZOPHRENIA
	HEART MURMUR/VALVE ISSUE		ANEMIA OR ABNORMAL BLEEDING		ATTEMPTED SUICIDE
	CANCER		NAUSEA/VOMITING		SKIN PROBLEMS

PLEASE LIST OTHER MEDICAL PROBLEMS (NOT INCLUDED ABOVE):

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PREGNANT OR POSSIBILITY OF PREGNANCY?: YES OR NO LAST MENSTRUAL PERIOD: ____________________

FAMILY MEDICAL HISTORY (Please include significant medical problems and relationship to you):

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I CERTIFY THAT I PERSONALLY HAVE COMPLETED THIS MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE. I AGREE TO SEEK IMMEDIATE HELP FROM A SUICIDE HOTLINE, LICENSED MENTAL HEALTH PROVIDER, AND/OR HOSPITAL EMERGENCY DEPARTMENT IN THE EVENT THAT MY SYMPTOMS WORSEN OR I EXPERIENCE AN INCREASE IN SUICIDAL THOUGHTS, FEELINGS, OR URGES.

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SIGNATURE OF PATIENT/GUARDIAN PRINTED NAME DATE