ADULT MEDICINE INSTITUTE
& DIAGNOSTIC CENTER
Dedicated To Total Body Care

PATIENT REGISTRATION FORM

Patient Name: Last _____ First _____ MI _____

Social Security #:____-____-____ Date of Birth:__/__/__ Gender:(circle one) male/female

Mailing Address: _____ City: _____ State:_____ Zip: _____

Home Phone #:(___)_____ Cell:(___)_____ Other: (___)_____

Employer: _____ Employer Phone # :(___)_____ Ext:____

Emergency Contact:_____ Phone #:(___)_____ PCP: Dr. Vazquez

INSURANCE COVERAGE

PRIMARY: Insurance Company_____

SECONDARY: Insurance Company_____

CONSENT FOR SERVICES AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to medical evaluation, testing and/or treatment provided to me by the staff of Adult Medicine Institute and Diagnostic Center. I also understand that Adult Medicine Institute and Diagnostic Center may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Dr. Vazquez and agree to pay any remaining balance once my insurance plan has processed my claim. I have received the Adult Medicine Institute and Diagnostic Center notice of privacy practices.

X _____ Date:_____

signature of patient or parent/guardian if minor

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Date of Last Physical Exam: _____

What is the reason for this visit? _____

Please list any Medications you are currently taking: _____

_____

Please list any Allergies you have: _____

_____

Symptoms: Check any symptoms you currently have or have had in the past year.

General
- o Chills
- o Depression
- o Dizziness
- o Fainting
- o Fever
- o Forgetfulness
- o Headache
- o Loss of Sleep
- o Nervousness
- o Numbness
- o Sweats

Muscles/Joint/Bone
- o Arms
- o Hips
- o Back
- o Legs
- o Feet
- o Neck
- o Hands
- o Shoulders

Genito-Urinary
- o Painful Urination
- o Blood in Urine
- o Frequent Urination
- o Lack of Bladder Control

Gastrointestinal
- o Poor Appetite
- o Bloating
- o Bowel Changes
- o Constipation
- o Diarrhea
- o Excessive hunger
- o Excessive thirst
- o Gas
- o Hemorrhoids
- o Indigestion
- o Nausea
- o Rectal Bleeding
- o Stomach Pain
- o Vomiting
- o Vomiting blood

Cardiovascular
- o Chest Pain
- o High Blood Pressure
- o Irregular Heart Beat
- o Low Blood Pressure
- o Poor Circulation
- o Rapid Heart Beat
- o Swelling of ankles
- o Varicose Veins

Eye, Ear, Nose, Throat
- o Bleeding gums
- o Blurred vision
- o Crossed eyes
- o Difficulty swallowing
- o Double vision
- o Earache
- o Ear discharge
- o Hay fever
- o Hoarseness
- o Hearing loss
- o Nose bleeds
- o Persistent cough
- o Ringing in ears
- o Sinus problems
- o Vision flashes
- o Vision halos

Skin
- o Bruise easily
- o Hives
- o Itching
- o Change in moles
- o Rash
- o Scars
- o Sore that won't heal

Men Only
- o Breast lump
- o Testicle lump
- o Penis discharge
- o Sore on penis
- o Erection difficulties
- o Other _____

Prostate problems? **Y/N**

Female Only

Are you pregnant? **Y/N**

Have you had a mammogram?
- o Yes date _____
- o No

Date of last:

Menstrual Period _____

Pap Smear _____

Number of children _____

Miscarriages? **Y/N**

Vaginal Infections? **Y/N**

Conditions: Check any you have or have had
- o Aids
- o Alcoholism
- o Anemia
- o Anorexia
- o Appendicitis
- o Arthritis
- o Bleeding disorder
- o Breast lump
- o Bronchitis
- o Bulimia
- o Cancer
- o Cataracts
- o Chemical dependency
- o Chickenpox
- o Diabetes
- o Emphysema
- o Epilepsy
- o Glaucoma
- o Goiter
- o Gonorrhea
- o Gout
- o Heart Disease
- o Hepatitis
- o Hernia
- o Herpes
- o High Cholesterol
- o HIV Positive
- o Liver Disease
- o Measles
- o Migraine Headache
- o Mononucleosis
- o Multiple Sclerosis
- o Mumps
- o Pacemaker
- o Pneumonia
- o Polio
- o Psychiatric care
- o Rheumatic Fever
- o Scarlet Fever
- o Stroke
- o Suicide Attempt
- o Thyroid Problems
- o Tonsillitis
- o Tuberculosis
- o Typhoid Fever
- o Ulcers
- o Venereal Disease

Name: _____ **Date:** _____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Patient Signature _____ **Date:** _____