

PATIENT REGISTRATION FORM

Date: Time:

Patient Information

Have you been to RediClinic before? Yes No

Last Name First Name MI

Gender: MALE FEMALE / /
Date of Birth

Address Apt. #

City State Zip Code

--

Daytime Phone

Email Address

Marital Status: MARRIED SINGLE

Emergency Contact Name Relationship

--

Emergency Contact Phone

Employer Name

How did you hear about us? (please circle one)

Family/Friend Former Patient Employer Physician/Emergency Room
Community Marketing Newspaper/Magazine In-store Marketing Television
Radio Mailer
Other:

Insurance Information

Patient Relation to Insured:

Self Spouse Child Other

Insurance Provider

Group # Member #

If Other than Self, Complete Below

Policy Holder First Name

Policy Holder Last Name

/ /

Policy Holder DOB

ATTENTION

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Please have your insurance information and picture ID available. Thank You!**

Allergies: Check all that apply.

- None
- Bee sting
- Eggs
- Aspirin
- Drug
- Drug
- Other
- Other

Medications:

Prescription / Non-Prescription / Vitamins / Birth Control / Herbs

- None
- Aspirin
- Drug
- Drug
- Drug
- Drug

Females Only

Pregnant:

Yes No

Due Date

Last menstrual period

Last PAP

**PATIENT REGISTRATION
FORM**
Primary Care Physician

 Do you have a Primary Care Physician? YES NO

PCP Name _____

PCP City _____

PCP State _____

PCP Zip Code _____

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PCP Phone _____

PCP Fax _____

Purpose of Visit Today

-
- Illness/Injury***
-
- Immunization
-
-
- Physical Exam
-
- Other _____
-
-
- Bloodwork _____

*****Review of Symptoms: Please check all that apply**
Constitutional

-
- Recent fever/sweats
-
-
- Wt loss/gain
-
-
- Fatigue/weakness

Eyes

-
- Change in vision
-
-
- Redness/pain/discharge

Ears/Nose/Throat/Mouth

-
- Difficulty hearing/ringing in ears
-
-
- Congestion/hay fever/allergies
-
-
- Trouble swallowing
-
-
- Ear pain
-
-
- Throat Pain

Cardiovascular

-
- Chest pains/discomfort
-
-
- Palpitations
-
-
- Short of breath with exertion

Skin

-
- Rash
-
-
- New or change in mole

Neurological

-
- Headaches
-
-
- Memory loss
-
-
- Fainting

Psychiatric

-
- Anxiety/stress
-
-
- Sleep problem

Duration of Symptoms? _____

Respiratory

-
- Cough/wheeze
-
-
- Coughing up blood

Gastrointestinal

-
- Heartburn/reflux
-
-
- Blood or change in bowel movement
-
-
- Nausea/vomiting/diarrhea
-
-
- Pain in abdomen

Genitourinary

-
- Painful/bloody urination
-
-
- Leaking urine
-
-
- Discharge: penis or vagina
-
-
- Unusual vaginal bleeding
-
-
- Concern with sexual functions

Musculoskeletal

-
- Muscle/joint pain
-
-
- Recent back pain

Blood/Lymphatics

-
- Unexplained lumps
-
-
- Easy bruising/bleeding

Endocrine

-
- Cold/heat intolerance
-
-
- Increase thirst/appetite

None

Medical History:

Check all that apply at this time.

General

-
- High blood pressure
-
-
- High cholesterol
-
-
- Asthma
-
-
- COPD
-
-
- Heart trouble
-
-
- Diabetes
-
-
- Stroke
-
-
- Thyroid disorder
-
-
- Lung problem
-
-
- Digestive tract disorder
-
-
- Cancer
-
-
- Disease of the kidney
-
-
- Arthritis
-
-
- Liver problem/jaundice
-
-
- Malaria
-
-
- Tuberculosis
-
-
- Nervous disorder

Surgical History

-
- Tonsillectomy
-
-
- Appendectomy
-
-
- Gall bladder surgery
-
-
- Heart surgery or stint
-
-
- Hysterectomy
-
- Tubal
-
-
- Dialysis or indwelling catheter
-
-
- Other: _____

 No known problems

Social

-
- None
-
-
- Tobacco (smoking)
-
-
- Alcohol
-
-
- Caffeine

Family History

-
- No known problems
-
-
- Asthma _____
-
-
- High blood pressure _____
-
-
- Heart trouble _____
-
-
- Diabetes _____
-
-
- Stroke _____
-
-
- Thyroid problem _____
-
-
- Cancer _____
-
-
- Other: _____

**** FOR INTERNAL USE ONLY****

BP: _____

Height: _____

Resp: _____

Weight: _____

Temp: _____

Blood Sugar: _____

Pulse: _____

Oxygen Saturation: _____