Evansville PRIMARY CARE
Family Medicine at its Best

Patient Registration Form

Patient Name: _____ _____
(Last) (First) (MI) (Preferred Name)

Date of Birth _____/_____/_____ ☐ M ☐ F Email _____ SSN _____

Address _____ City/ST_____ Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

☐Married ☐ Divorced ☐ Single ☐ Widowed ☐ Legally Separated

Race _____ Hispanic or Latino? Y or N Language _____

Emergency Contact _____
(Name) (Relationship) (Phone)

Preferred Pharmacy and Location _____

☐ Spouse ☐ Parent information (if patient is a minor, fill out both sections completely for each parent)

Name _____
Address_____
City/St/Zip _____
Phone _____
Employer _____

Name _____
Address _____
City/St/Zip _____
Phone _____
Employer _____

Primary Insurance

Name of Insurance _____
Policy Holder _____
Relationship to Patient _____
DOB _____ SSN# _____
Address _____
_____

Secondary Insurance

Name of Insurance _____
Policy Holder _____
Relationship to Patient _____
DOB _____ SSN# _____
Address _____
_____

Assignment of Insurance Benefits and Financial Responsibility Agreement: I hereby authorize my signature on all insurance and Medicare claim forms at the office of Evansville Primary Care for payment to him/her for service rendered to me or the patient. I authorize this office to make and send copied of my/the patients' medical records that may be needed to file my insurance claims. I understand that I am responsible for charges incurred regardless of whether my insurance pays or not. I understand and agree to pay any unpaid balances that may be assigned to a third part collection agency for collections or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection fee may be added to my account. I understand and agree to the terms above.

Signature: _____ Date _____

Patient Medical History Questionnaire

Patient Name _____ DOB _____ SSN # _____

Please list all your hospitalizations and/or surgeries (use back if necessary): ☐ Check here if none

Month/Year	Hospital	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medical illnesses, including childhood diseases: ☐ Check here if none

1) _____ 4)_____

2) _____ 5) _____

3) _____ 6) _____

Do you smoke? ☐Yes ☐No How often? _____
Do you drink alcohol? ☐Yes ☐No How often? _____
Do you eat a balanced diet? ☐Yes ☐No
Are you on a special diet? ☐Yes ☐No If yes, please explain: _____
Do you drink caffeine? ☐Yes ☐No How often? _____
Do you exercise? ☐Regularly ☐Occasionally ☐Rarely ☐Never
Have you ever had a blood transfusion? ☐Yes ☐No
Have you ever struggled with drug and/or alcohol abuse? ☐Yes ☐No If yes, please explain:
_____

Please list all current medications you are taking (please include over the counter medications like: aspirin, laxatives, antacids, birth control, etc.)

1) _____ 4) _____ 7)_____

2) _____ 5) _____ 8) _____

3)_____ 6) _____ 9) _____

☐ Check here if none *Use the back of this form if needed

Social History

Religion _____

Have you been outside of the country in the last 30 days? ☐ Yes ☐ No If yes, where? _____

_____

How would you rate your overall current health? ☐Excellent ☐Good ☐Fair ☐Poor

Family History

Patient Name _____ DOB _____ SSN # _____

Please provide the following information regarding your family:

Family Member	**Age**	**Health problems(if deceased, give cause of death and age)**
Mother	____	_____
Father	____	_____
Sister(s)	____	_____
	____	_____
	____	_____
Bother(s)	____	_____
	____	_____
	____	_____
Daughter(s)	____	_____
	____	_____
	____	_____
Son(s)	____	_____
	____	_____
	____	_____

Do **any** of your blood relatives have problems involving:

Heart? ____ Blood Pressure? ____ Lungs? ____ Stomach? ____ Kidney? ____ Liver? ____ Diabetes? ____

Cancer/Tumors? ____ Epilepsy/Seizures? ____ Stroke? ____ Emotion/Psychiatric? ____ Arthritis? ____

Details:_____

_____

_____

Review of Functions

Patient Name _____ DOB _____ SSN # _____

If any of the following are currently relevant to you, please mark them with an X:

General
___Weakness
___ Fatigue
___ Cold chills
___ Fever
___ Night sweats
___ Body aches
___ Change in appetite
___ Change in weight
___ Skin problems
___ Anemia/blood disease
___ Diabetes
___ Thyroid disease/goiter
___ Cancer/tumors

Neurologic
___ Severe headaches
___ Fainting
___ Seizures/convulsions
___ Muscle jerking
___ Tremors
___ Dizziness
___ Tingling
___ Numbness
___ Paralysis
___ Muscle weakness
___ Incoordination
___ Difficulty walking
___ Difficulty speaking
___ Stroke
___ Memory loss

Eyes
___ Blurred Vision
___ Double Vision
___ Glaucoma
___ Cataracts
___ Color blind

Ears/Nose/Throat
___ Hearing loss
___ Ringing in ears
___ Ear pain
___ Ear drainage
___ Nosebleeds
___ Chronic stuffy nose
___ Post nasal drip
___ Sinus infections
___ Toothache
___ Chronic sore tongue
___ Chronic sore gums
___ Sore(s) in mouth
___ Persistent hoarseness
___ Swelling in neck

Lungs
___ Shortness of breath
___ Asthma
___ Bronchitis
___ Emphysema
___ Chronic Cough
___ Sputum/phlegm
___ Coughing up blood
___ Pneumonia
___ Tuberculosis
___ Dust/Fume exposure

Heart
___ Chest pain
___ Difficulty breathing
___ Winded with exercise
___ Breathing problems at night
___ difficulty lying flat
___ Irregular heartbeat
___ Rapid heartbeat
___ High blood pressure
___ Heart attack
___ Heart failure
___ Heart murmur
___ Swollen ankles
___ Varicose veins
___ Leg ulcers
___ Blood clots
___ Pain in legs when walking
___ Rheumatic fever
___ Bypass operations
___ Artificial heart valve
___ Artery surgery
___ High cholesterol

Stomach/Intestines
___ Chronic abdominal pain
___ Persistent nausea
___ Persistent vomiting
___ Vomiting blood
___ Chronic diarrhea
___ Chronic constipation
___ Black tarry stool
___ Bleeding form rectum
___ Clay-colored stool
___ Skin turning yellow
___ Hemorrhoids
___ Heartburn
___ Ulcers
___ Liver disease
___ Abdominal distension
___ Pancreatitis
___ Difficulty swallowing
___ Gallbladder problems
___ Appendicitis

Urinary Tract/Kidneys
___ Pain in urination
___ Frequent urination
___ Scanty urination/dribbling
___ Excess nighttime urination
___ Leakage of urine
___ Bedwetting
___ Bloody urine
___ Strong/dark urine
___ Retention of urine
___ Urinary shutdown/kidney failure
___ Urinary/kidney infection
___ Kidney stones
___ Gout

For Women Only
___ Irregular periods
___ Painful periods
___ Heavy periods
___ Bleeding between periods
___ Vaginal discharge
___ Pelvic disease
___ Sexual problems
___ Menopause
___ Breast lumps, discharge, pain

____ Age at first period

____ Number of pregnancies

____ Number of births

_____ Method of birth control

_____ Last menstrual period

_____ Last PAP smear

For Men Only
___ Trouble starting urination
___ Prostate disease
___ Discharge from penis
___ Sore(s) on Penis
___ STD/STI
___ Pain/lumps/swelling in testicles
___ Problems with erection or sex
___ Hernia

Muscles/Joints
___ Joint pain/swelling/stiffness
___ Arthritis
___ Chronic back pain
___ Fractures
___ Limited motion

Psychiatric/Emotional
___ Depression
___ Anxiety/Nervousness
___ Nervous breakdowns
___ Personality changes
___ Sleep disturbances
___ Excessive worrying
___ Sudden mood swings

If there is any additional information you feel to be important, please include it here:

_____

Signature _____ **Date** _____