Patient Registration & Health Questionnaire

URGI-MED FAMILY MEDICAL CENTER
FAMILY MEDICINE WITH DEDICATION
AND COMPASSION

PATIENT

Last Name First Name Initial

Street Address

City State Zip Code

Social Security Number – –

If under 18, parent/guardian

Last Name First Name Initial

Marital Status (circle one) **S M W D Sep**

Birth Date (Month/Day/Year)

Occupation Employer

Phone Numbers

Home ( ) – Cell ( ) –

Work ( ) –

SPOUSE

Last Name First Name Initial

Occupation Employer

Phone Numbers

Home ( ) – Cell ( ) –

Work ( ) –

REASON FOR VISIT

MEDICATIONS & HOSPITALIZATIONS

List all prescription and over the counter medications you are currently taking:

Prescription/Medication Name	Strength	Frequency	Rx	OTC	Prescription/Medication Name	Strength	Frequency	Rx	OTC
			☐	☐				☐	☐
			☐	☐				☐	☐
			☐	☐				☐	☐

List medications that you are allergic to: ☐ I do not have any drug allergies

List below the year and reason if you have been previously hospitalized: *(do not include normal pregnancies)* ☐ I have not been hospitalized

Year/Reason:

Year/Reason:

Year/Reason:

Year/Reason:

FAMILY HISTORY

	Alive & Well	Deceased	Age and Cause of Death
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Does/did your father, mother or sibling have any of the following:
*(Write **F** for Father, **M** for Mother, **S** for Sibling)*

High Blood	_____Hay Fever	_____Mental Illness
_____Pressure	_____Arthritis	_____Alcoholism
_____Heart Disease	Kidney	_____Bleeds Easily
_____Epilepsy	_____Disease	_____Anemia
_____Diabetes	_____Glaucoma	_____Psoriasis
_____Cancer	_____Stroke	_____Eczema
_____Asthma	_____Migraine	

SOCIAL HISTORY

Check all that apply:

Caffeine Use ☐ Often ☐ Occasionally ☐ Never

Drink Alcohol ☐ Often ☐ Occasionally ☐ Never

Tobacco Use ☐ No, never smoked

☐ Used to smoke, quit smoking in _____

☐ Currently smoke, have smoked for _____ years

☐ cigarettes ☐ cigars ☐ pipe ☐ smokeless

Daily amount of _____

FOR WOMEN ONLY

Regular Menstrual Period ☐ Yes ☐ No

Menopausal Symptoms ☐ Yes ☐ No

Birth Control Method B.C. Pill (Brand)

____ No. of Pregnancies ____ No. of Live Births ____ No. of Miscarriages

To reorder additional forms, fax your reorder form to 1-888-633-6768 or call us at 1-888-MD-Forms.

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