PATIENT REGISTRATION *(please print clearly)*

PATIENT INFO

**** All Fields Must Be Completed ****

Date:_____ Social Security # :_____

Name:_____ MI_____ Last:_____ Suffix:_____ First

Sex: M / F Date of Birth:_____ Age: _____

(Please circle one)

Marital Status: Single Married Divorced Widowed Legally Separated

Nationality: African Amer. Amer. Indian Asian Caucasian Hispanic Other

Ethnicity: Latino/Hispanic Other Refused

Primary Language:

PATIENT INFO CONT.

Patient's Permanent Address

Address:_____

Address:_____ City:_____

State:_____ Zip:_____

Please Circle Preferred Number for Primary Communication

Home Phone:____

Work Phone:_____

Cell Phone:_____

E-mail Address:_____

Write in NONE if no e-mail address is available

Employment status:(Please Circle One)

EMPLOYED SELF EMPLOYED RETIRED DISABLED UNEMPLOYED STUDENT

Employer Name _____

Address: _____

City:_____

State:_____ Zip:_____ Home

Phone:_____

Work Phone:_____

Home Phone:_____

Work Phone:_____

Who is your Primary Care Doctor: _____

Who can we thank for referring you today? (Please circle one) Referral Svc Walk-In Provider Directory Friend Website

Referring Physician:_____ Self Referred Billboard Other _____

GT INFO

Financial Responsible Party or Guarantor Name: _____

DOB: _____

Address:_____ City: _____

Address:_____ State:_____ Zip: _____

INSURANCE INFO

Primary Carrier:_____

Subscriber:_____

Subscriber DOB:_____

Subscriber ID #:_____

Secondary Carrier:_____

Subscriber:_____

Subscriber DOB:_____

Subscriber ID #:_____

EMR CONT

Name:_____ Relationship to pt:_____

Phone: _____ Work Phone: _____ SSN:_____

EXTENDED INFORMATION

Who is the legal guardian for the patient? Please circle one: **Self** or **Other**

** If other is selected please print name and phone number*

Name:_____ Phone:_____

Smoker? Please circle one: **Current Smoker** **Former Smoker** **Never Smoked**

Do you have a visual impairment that would hinder you from reading written materials from your physician?
Please circle one: **Yes** or **No**

Do you have a hearing impairment that would impede verbal communication with your provider?
Please circle one: **Yes** or **No**

Date _____

New Patient History

(Please Print Clearly)

Patient Name:_____**Date of Birth**: ___/__ /_____

Sex: Male____ Female ____

Reason for Visit: (Please list your major medical concerns)

_____

_____

Allergies	**Reaction**

MEDICATIONS Please list all medications you are taking including prescription, over the counter, vitamins and herbal

(Please list each Medication and dosage)

Medication Name	Dosage	How Many Times a Day?	Refill Needed? Yes / No

Preferred Pharmacy _____ _____

Name **Location/Address**

Patient Initials_____

Date_____

Name_____ DOB _____

PAST MEDICAL HISTORY

Medical History – Please check any of the following that you have been diagnosed with.

- ☐ Anorexia/Bulimia
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blocked Arteries
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Cancer Type:_____
- ☐ Cataracts
- ☐ Chronic Constipation
- ☐ Colon Polyps
- ☐ COPD
- ☐ Macular Degeneration
- ☐ Degenerative Disc Disease
- ☐ Diabetes/Pre-Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Frequent Urinary Infections
- ☐ Gallstones
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herniated Disc
- ☐ High Blood Pressure
- ☐ High Cholesterol/Triglycerides
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Insomnia
- ☐ History of Blood Transfusion
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Meningitis
- ☐ Obesity
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease/Poor Circulation
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ Ulcers
- ☐ Alcohol Abuse Quit Date: _____
- ☐ Substance Abuse Quit Date:_____

Any Others:_____

Surgical / Procedure History – Please check any of the following you have had, and list the month/year performed.

- ☐ Appendectomy _____
- ☐ Bunionectomy _____
- ☐ Carotid Surgery _____
- ☐ D&C _____
- ☐ Lumpectomy _____
- ☐ Lasik Surgery _____
- ☐ Tonsillectomy _____
- ☐ Tubal Ligation _____
- ☐ Uterus Removal _____
- ☐ C-Section _____
- ☐ Cataract Removal _____
- ☐ Hemorrhoidectomy _____
- ☐ Hip Surgery _____
- ☐ Kidney Stones _____
- ☐ Hip Replacement _____
- ☐ Prostate Removed _____
- ☐ Ovaries Removed _____
- ☐ Joint Surgery _____
- ☐ Cardiac Bypass _____
- ☐ Gallbladder Removal _____
- ☐ Hernia Repair _____
- ☐ Cardiac Stents _____
- ☐ Thyroidectomy _____
- ☐ Knee Replacement _____
- ☐ Vasectomy _____
- ☐ Back Surgery _____

Any Others:_____

Hospitalizations – Please list any other hospitalizations you may have had.

1. Reason: _____
   Date: _____
   Hospital: _____
2. Reason: _____
   Date: _____
   Hospital: _____
3. Reason: _____
   Date: _____
   Hospital: _____
4. Reason: _____
   Date: _____
   Hospital: _____

Women's Health

Number of Vaginal Deliveries:_____
Number of Miscarriages:_____
Number of Abortions:_____
Age of First Period:_____

Number of Pregnancies:_____
Number of C-Sections:_____
Abnormal PAP's?_____

Patient Initials_____

Date_____

Name_____ DOB _____

PHYSICIANS YOU HAVE RECENTLY SEEN

Prior Primary Care Physician: Name: _____ Location: _____

Specialists: Please list most recent physician and specialists you see or have seen;

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

HEALTH MAINTENANCE

If you have had any of the following performed, please check the box and list the month/year

□ Last Physical Exam _____
□ Last EKG _____
□ Last Eye Exam _____
□ Labs including a Cholesterol Screen _____

□ Colonoscopy _____
□ Fecal Occult Blood Test (Blood in stool) _____

□ Shingles Vaccine (Zostavax) _____
□ Human Papilloma Virus Vaccine (HPV-Gardasil) _____
□ Vaccines Against Hepatitis _____
□ Influenza Vaccine _____

□ Mammogram (Females Only) _____
□ Clinical Breast Exam (Females Only) _____
□ Pap Smear (Females Only) _____
□ Bone Density _____

□ PSA (Males Only) _____

□ Tetanus Diphtheria (Td) _____
□ Tetanus Diphtheria Pertusis (Tdap) _____
□ Pneumonia Vaccine (Pneumovax) _____
□ TB Screening _____

SOCIAL HISTORY

What is your current marital status? □ **Single** □ **Married** □ **Divorced** □ **Widowed** □ **Other:** _____

Number of Children: _____ Ages of Children: _____

With whom do you currently live?
□ **Self** □ **Sibling** □ **Spouse** □ **Spouse/Children** □ **Parents** □ **Significant Other** □ **Friend/Roommate**

Your Occupation: _____ If retired, from what: _____

Please indicate the highest level of education you have received:

_____

Hobbies/interests and physical activities: _____

Please list any dietary restrictions or special diets you may follow: _____

Regular Exercise **YES** **NO** Type:_____Frequency:_____

Patient Initials_____

Name_____ DOB _____ Date_____

Operate a motor vehicle? **YES** **NO** Use a seatbelt? **YES** **NO**

Hazardous chemicals labeled & kept in a safe place? **YES** **NO**

Do you know the number to Poison Control Center? **YES** **NO**

Do you currently use tobacco products? **NO** **YES** Type: _____

Amount per day? _____How long have you used? _____

Do you have a history of using tobacco products? **NO** **YES** Type & Amount: _____

How long did you use: _____When did you quit? _____

How much alcohol do you typically drink in **one week?**

□ **I do not drink alcohol** □ **Less than one** □ **Drinks per week:**_____

Do you use drugs? **NO** **YES** What type? _____ Do you have a history of drug addiction? **YES** **NO**

Are you sexually active? **YES** **NO** **NEVER** Do you use condoms? **YES** **NO**

Sexual Partners: **Male**_____ **Female**_____ **Both**_____

Do you have any history of STD's? **NO** **YES** **If YES**, what type? _____

The CDC recommends that everyone be screened for HIV. Do you have any concerns about possible exposure that you would like to discuss or be tested for? **YES** **NO**

Are you currently, or have you ever been, a victim of domestic violence? **YES** **NO**

Do you have any spiritual/religious needs/restrictions? If so, please indicate:_____

_____

_____

Do you need help with the following? (check everything that applies)

_____Dressing
_____Toileting
_____Bathing or showering
_____Walking
_____Eating
_____Getting in and out of bed
_____Checkbook balancing
_____Shopping
_____Answering the phone
_____Taking your medications

Patient Initials_____

Date_____

Name_____ DOB _____

During the **past four weeks**, have you often been bothered by feeling down, depressed or hopeless? **YES NO**

During the **past four weeks**, have you often been bothered by lack of interest or pleasure in doing things? **YES NO**

During the **past four weeks**, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself)

YES, as much as I wanted YES, quite a bit YES, some YES, a little NO, not at all

Have you fallen in the past year? **YES NO**

Do you have complaints of balance or difficulty walking? **YES NO**

How often do you have trouble taking medications the way you have been told to take them?

- ☐ **I do not have to take medicine**
- ☐ **I always take them as prescribed**
- ☐ **Sometimes I take them as prescribed**
- ☐ **I seldom take them as prescribed**

If you do have trouble, are there specific barriers that interfere with medication adherence?

Please check all that apply:

- ☐ **Cost/Financial constraints**
- ☐ **Remembering doses**
- ☐ **Understanding importance of taking medications**
- ☐ **Ability to read prescription labels or instructions**
- ☐ **Religious beliefs**
- ☐ **Cultural differences**
- ☐ **Other:**

Do you have an advanced directive/living will? **YES NO**

Would you like to discuss living wills/advanced directives with your provider today? **YES NO**

If you use any other medical suppliers (oxygen, CPAP, home health, etc.) please list those company names below:

_____

_____

_____

_____

_____

Patient Initials_____

Vaccine Administration Record for Adults

Patient name: _____

Birthdate: _____ Chart number: _____

Clinic name and address

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding source (F,S,P)[2]	Route[3] & Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Td, Tdap) Give IM.[3]									
Hepatitis A[6] (e.g., HepA, HepA-HepB) Give IM.[3]									
Hepatitis B[6] (e.g., HepB, HepA-HepB) Give IM.[3]									
Human papillomavirus (HPV2, HPV4) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give SC.[3]									
Varicella (VAR) Give SC.[3]									
Pneumococcal (e.g., PCV13, conjugate; PPSV23, polysaccharide) Give PCV13 IM.[3] Give PPSV23 IM or SC.[3]									
Meningococcal (e.g., MenACWY, conjugate; MPSV4, polysaccharide) Give MenACWY IM.[3] Give MPSV4 SC.[3]									

See page 2 to record influenza, Hib, zoster, and other vaccines (e.g., travel vaccines).

How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (sanofi pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac (sanofi pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4	Gardasil (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
PCV13, PPSV23	Prevnar 13 (Pfizer); Pneumovax 23 (Merck)
MenACWY	Menactra (sanofi pasteur); Menveo (Novartis)
MPSV4	Menomune (sanofi pasteur)

Technical content reviewed by the Centers for Disease Control and Prevention

For additional copies, visit www.immunize.org/catg.d/p2023.pdf • Item #P2023 (4/14)

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Vaccine Administration Record for Adults

Patient name: _____

Birthdate: _____ Chart number: _____

Clinic name and address

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] & Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[6] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Influenza (e.g., IIV3, trivalent inactivated; IIV4, quadrivalent inactivated; RIV, recombinant inactivated; LAIV4, quadrivalent live attenuated) Give IIV and RIV IM.[3] Give LAIV IN.[3]									
Hib Give IM.[3]									
Zoster (Zos) Give SC.[3]									
Other									

See page 1 to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, pneumococcal, and meningococcal vaccines.

How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.

Abbreviation	Trade Name and Manufacturer
LAIV (Live attenuated influenza vaccine)	FluMist (MedImmune)
IIV (Inactivated influenza vaccine), RIV (recombinant influenza vaccine)	Afluria (CSL Biotherapies); Agriflu (Novartis); Fluarix (GSK); Flublok (Protein Sciences Corp.); Flucelvax (Novartis); FluLaval (GSK); Fluvirin (Novartis); Fluzone, Fluzone Intradermal, Fluzone High-Dose (sanofi pasteur)
Hib	ActHIB (sanofi pasteur); Hiberix (GSK); Pedvaxl-Hib (Merck)
ZOS (shingles)	Zostavax (Merck)

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Patient Instructions for Communication Preferences

I authorize my doctor or staff to **leave messages** including certain medical information:

☐ YES May leave messages on my answering machine or voice mail:

☐ at HOME ☐ at WORK ☐ on my MOBILE / CELL PHONE

☐ YES May share information with the following individuals:

☐ My spouse or significant other _____
☐ my son or daughter _____
☐ any relative_____
☐ other_____

This information may include information such as:

☐ Lab test and x-ray results
☐ Information regarding prescription refills
☐ Information regarding appointments
☐ Instructions regarding treatments or medications
☐ All information, no exceptions

☐ NO Do not leave messages on my answering machine or voice mail. I prefer that my doctor or staff speak to me personally regarding any medical information.

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

_____ _____
Signature Date

Scan to NOTIFICATION PREFERENCES – AMBULATORY

Patient Label