MY MEDICAL CLINIC
PATIENT REGISTRATION

Patient Demographic: ☐ Male ☐ Female DOB: _____

Last Name: _____ First Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell Phone: _____ Work Phone: _____

Preferred Method of Contact (please check one): ☐ Home ☐ Cell Phone ☐ Work Phone

Email Address: _____ **May we contact you via Email/Text?** ☐ Yes ☐ No

Responsible Party Information (if patient under 18):

Last Name: _____ First Name: _____ DOB: _____

Relationship to Patient: _____ Marital Status: _____ Sex: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Plan: _____ Member ID # _____ Group # _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

Policy holder address (if different from patient): _____

Secondary Insurance Plan: _____ Member ID # _____ Group # _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

Policy holder address (if different from patient): _____

Assignments of Benefits

Sign Your Name as It Appears On Your Insurance Card

- **Insurance (Not Medicare):** I authorize my insurance company to pay benefits on my behalf directly to My Medical Clinic. I authorize My Medical Clinic to provide my insurance company, any insurance information necessary to process claims for services rendered to me.

Sign: _____

- **Medicare Only:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Sign: _____

- **Secondary Insurance:** If you have a supplemental policy and it is a policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my carrier any information needed to determine these benefits or the benefits payable for related services.

Sign: _____

How did you hear about our practice? ☐ Insurance Plan ☐ Advertisement ☐ Family ☐ Friend ☐ Internet

I acknowledge that I have been provided with a copy of Privacy Practices from My Medical Clinic.

_____ _____

Signature of Patient (or Legal Representative) **Date**

My Medical Clinic - Medical History

Reason for visit: _____

Drug allergies (list reaction): _____ No known drug allergies

Drug	Reaction

Other allergies (food, environmental):

Current medications:
-List all medications including prescription, over the counter and herbal/dietary supplements

Drug	Dose (strength)	Frequency

Race/Ethnicity:

- ☐ White (not of Hispanic origin)
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian
- ☐ Black or African American (not Hispanic origin)
- ☐ Hispanic

Preferred Language? _____

Emergency Contact? _____

May we discuss your medical conditions with this person? ☐ YES ☐ NO

May we leave a message on your home answering machine/voice mail? ☐ YES ☐ NO

May we leave a message at your work to return our call? ☐ YES ☐ NO

Preferred Pharmacy and location? _____

What is their phone number? _____

Immunizations

☐	Chicken Pox (varicella)	Date: _____
☐	Flu shot	Date: _____
☐	Hepatitis A	Date: _____
☐	Hepatitis B	Date: _____
☐	HPV (gardasil)	Date: _____
☐	Meningococcal (meningitis)	Date: _____
☐	MMR (measles, mumps, rubella)	Date: _____
☐	Pneumococcal (pneumonia)	Date: _____
☐	Shingles	Date: _____
☐	Tdap (tetanus and whooping cough)	Date: _____

Medical History: Please check if you've had any of the following

Arthritis		Kidney disease	
Asthma		Kidney stones	
Attention deficit		Liver disease (hepatitis, cirrhosis, etc)	
Blood clotting disorders		Migraine headaches	
Bowel issues (diverticulitis, constipation, diarrhea, etc)		Osteoporosis	
Cancer		Other bone issues	
Chronic respiratory infection (ie TB)		Other endocrine disorders (hormones)	
COPD/emphysema		Other immune disease	
Coronary artery disease (heart disease)		Other neurological problems	
Depression/Anxiety		Other psychological problems	
Diabetes		Pancreatitis	
Drug or Alcohol abuse		Poor circulation (claudication)	
Fibromyalgia		Sexually transmitted disease	
GERD/Acid Reflux		Sleep Apnea	
Heart murmur		Stroke	
Heart rhythm problem		Thyroid issues	
High blood pressure		Thyroid problem	
High cholesterol		Ulcers	
HIV infection			

Past Surgeries:

Procedure	Date

Family History:

Relationship	Alive/deceased	Cause of Death
Mother		
Father		
Sibling		
Sibling		
Sibling		
Sibling		

Current Occupation: _____

Past Occupation: _____

Education level:

- ☐ Less than 8th grade
- ☐ High school
- ☐ College
- ☐ Post graduate

Marital status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Domestic Partner

Children: ☐ YES ☐ NO **How Many?** _____

Caffeine intake:

- ☐ Coffee/Tea _____cups per day
- ☐ Pop _____ ounces per day
- ☐ Energy drinks _____cans per day

Alcohol intake:
Do you drink Alcohol? ☐ YES ☐ NO
How often? _____
How much at a sitting? _____
What type? _____

Tobacco:
Do you use tobacco products? ☐ YES ☐ NO
What type? _____
How often? _____
How many years have you used? _____
Have you tried to quit? ☐ YES ☐ NO

Illegal Drugs:
Do you use any street drugs? ☐ YES ☐ NO
What type? _____
How often? _____
How long? _____

Exercise:
What type? _____
How often? _____
How long? _____

Health Maintenance:
Last physical exam? _____
Last cholesterol check? _____
Last check for diabetes? _____
Last colonoscopy, sigmoidoscopy or stool cards (if over 50)? _____
Last bone density check? _____
Last eye exam by eye doctor? _____
Last dental visit? _____

Review of Systems:
General:

- ☐ Fever
- ☐ Chills
- ☐ Recent weight changes
- ☐ Changes in appetite
- ☐ Fatigue

ENT:

- ☐ Blurry Vision
- ☐ Changes in vision
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Red eyes
- ☐ Problems with hearing
- ☐ Ringing of ears
- ☐ Nasal congestion
- ☐ Runny nose
- ☐ Mouth sores
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Snoring
- ☐ Sore throat

Cardiovascular:

- ☐ Chest or arm pain with exertion
- ☐ Chest heaviness
- ☐ Pressure in chest
- ☐ Palpitations (skipped or extra beats)
- ☐ Heart murmur
- ☐ Lightheadedness when standing
- ☐ Shortness of breath when lying flat
- ☐ Unable to walk 1 flight of stairs
- ☐ Shortness of breath with walking (stroll)
- ☐ Swelling in legs
- ☐ Varicose veins
- ☐ Pain in legs with walking

Respiratory:

- ☐ Cough
- ☐ Shortness of breath at rest
- ☐ Wheezing
- ☐ Coughing up blood

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Blood in stools
- ☐ Black or tarry stools
- ☐ Heartburn (acid reflux)
- ☐ Difficulty swallowing
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Liver problems/hepatitis
- ☐ Hemorrhoids

Genitourinary:

- ☐ Difficulty urinating
- ☐ Frequency of urination
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Feeling like bladder isn't emptying
- ☐ Men: difficulty starting stream
- ☐ Pain in back

Hematologic:

- ☐ Easy bleeding or bruising

Skin:

- ☐ Rashes
- ☐ Changes in moles
- ☐ Dry skin
- ☐ Excema
- ☐ Itching

Musculoskeletal:

- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Difficulty with balance

Neurologic:

- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness
- ☐ Restless legs
- ☐ Seizures
- ☐ Weakness (on one side or the other)
- ☐ Tremors/shaking

Psychiatric:

- ☐ Anxiety/stress
- ☐ Depression
- ☐ Sleep issues
- ☐ Manic
- ☐ Do not feel safe in relationship or at home
- ☐ Alcohol overuse

Men Only:

Last PSA (prostate blood test)? _____

Last prostate check? _____

Sexually active? _____

Partner? ☐ Male ☐ Female ☐ Both

- ☐ Straining with urination
- ☐ Pain or lump in testicle
- ☐ Discharge from penis
- ☐ Prostate issues
- ☐ Difficulty with erection

Women Only:

Last Menstrual Period or year of menopause? _____

Age of first menstrual period? _____

Total number of pregnancies? _____

Number of living children? _____

Number of miscarriages? _____

Number of abortions? _____

Last PAP smear? _____

Last mammogram if over 40? _____

Sexually active? _____

Partner? ☐ Male ☐ Female ☐ Both

Method of birth control? _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme pain during period
- ☐ Vaginal itching/burning
- ☐ Unusual vaginal discharge
- ☐ Hot flashes
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Painful intercourse

Any other concerns that you have today?

_____

_____

_____

_____

_____

_____

_____

GAD-7

Over **the last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Total Score (office use only) _____

PHQ-9

Over the **last 2 weeks,** how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping to much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total score (office use only) _____

If you checked off any problems, how difficulty have these problems made it for you to do your work, t care of things at home or get along with people?

Not difficult at all	Somewhat difficult	Very difficult		Extremely difficult	