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Patient Registration and Health History Form

Today's Date ________________ Patient name ____
First MI Last

Date of birth: __________________ Sex: Female □ Male □

Married □ Single □ Other □ Full-time student □ Part-time student □ Employed □

Mailing address ____
Street Apt./Unit # City State Zip

Home phone # _________________________Cell ______________________ Work ______________________________

Phone numbers at which messages may be left for you ____

Emergency contact name, relation to you and phone number ____

____

Referred by/how did you hear about this doctor's office? ____
Name of person responsible for this account? ______________________________Relationship to you__________________

Phone number___________________________ Address____

Would you like to be on our e-newsletter list? We do not sell or give-away e-mails. We do not communicate about your medical care by e-mail. Our newsletter is published no more than once per month and notifies you about events, sales, coupons and practical health tips. If you would like to be included in the distribution, please neatly print your complete e-mail address here:

____

Health History

Known allergies (medications, food, environmental, etc.) ____

____

Are you pregnant, breastfeeding or planning to conceive? ____

Hospitalizations, major illnesses or trauma (note dates and procedures) ___________________________________

____

Date of last full blood work: ____
Any abnormalities within that bloodwork? ____
____

Date of last full physical examination: ____
Any abnormal findings? ____

Review of systems: Please indicate any personal history below.
Please circle appropriate response and explain (Yes) answers below:

Eyes
Yes No Eye disease or injury
Yes No Wear glasses/contacts
Yes No Glaucoma/cataracts
Yes No Blurred vision
Yes No Doubled vision

Ears/Nose/Mouth/Throat
Yes No Hearing loss or ringing
Yes No Earaches or drainage
Yes No Chronic sinus problem
Yes No Stuffy/runny nose
Yes No Frequent nose bleeds
Yes No Frequent sore throat
Yes No Other ________________

Chest/Heart/Lungs/Vascular
Yes No Chest pain
Yes No Heart murmur/Disease
Yes No High Blood Pressure
Yes No Heart Palpitation
Yes No Rapid or irregular pulse
Yes No Swelling of extremities
Yes No Varicose veins
Yes No Asthma
Yes No Chronic or frequent coughs
Yes No Emphysema
Yes No Lung disease
Yes No Night sweats
Yes No Wheezing
Yes No Shortness of breath
Yes No Coughing up blood
Yes No Other _____________________

Gastrointestinal
Yes No Abdominal pain
Yes No Recent changes in appetite
Yes No Changes in bowel habits
Yes No Recent constipation
Yes No Frequent diarrhea
Yes No Digestive disorder
Yes No Difficulty swallowing
Yes No Recurrent emesis (vomiting)
Yes No Gastric or duodenal ulcers
Yes No Hemorrhoids/Rectal fissures
Yes No Hernia
Yes No Jaundice
Yes No Black bowel movements
Yes No Vomiting blood
Yes No Intestinal inflammation
Yes No Gall Bladder disease
Yes No Other _____________________

Dermatological
Yes No Acne
Yes No Rosacea
Yes No Dermatitis/eczema
Yes No Psoriasis
Yes No Rashes
Yes No Hyperpigementation
Yes No Hypopigementaton
Yes No Discolored or changing moles
Yes No Other ____________________________

Genitourinary
Yes No Frequent urination
Yes No Burning or painful urination
Yes No Blood in urine
Yes No Kidney stones
Yes No Sexual difficulty
Yes No Prostate Disorder
Yes No Other ___________________________

Female
Yes No Abnormal pap smear
Yes No Ovarian cysts
Yes No Pelvic inflammatory disease
Yes No Vaginal discharge
Yes No Vaginal itching
Yes No Pregnancy _____
Yes No Miscarriages ____
Yes No Abortions ____
Yes No Infertility
Yes No Painful menses
Yes No Irregular menses
Yes No Fibrocystic disease
Yes No Breast mass
Yes No Breast pain
Yes No Breast discharge
Yes No Other ____________________________

Musculoskeletal/ Neurological
Yes No Arthritis
Yes No Chronic muscle pain
Yes No Vertebrae, disc problems
Yes No Back injury
Yes No Neck injury
Yes No Extremity injury
Yes No Swollen or painful joints or extremities
Yes No Bone infection
Yes No Amputation
Yes No Head Injury
Yes No Dizziness
Yes No Attention Deficit Disorders
Yes No Cluster headaches
Yes No Frequent headaches
Yes No Migraine
Yes No Paralysis, tremors, muscle weakness
Yes No Neuralgia/ numbness
Yes No Seizures/Convulsions
Yes No Periods of unconsciousness
Yes No Other ____________________________

Mental Health
Yes No Feeling of depression
Yes No Tendency to worry
Yes no Memory loss
Yes No Mental health disorder
Yes No Considerable nervousness
Yes No Difficulty sleeping
Yes No Considered suicide
Yes No Other

Endocrine
Yes No Hypothyroid
Yes No Hyperthyroid
Yes No Diabetes
Yes No Excessive thirst or urination
Yes No Heat or cold intolerance
Yes No Skin becoming dryer
Yes No Excessive sweating
Yes No Other

Hematologic/Lymphatic
Yes No Bleeding or bruising tendency
Yes No Anemia
Yes No Phlebitis
Yes No Past transfusion
Yes No Enlarged glands
Yes No Other ________________________

Allergic/Immunologic
Yes No Medication Allergies_________________
Yes No Food allergies_______________________
Yes No Environmental allergies_______________
Yes No Other ________________________

Infectious Disease
Yes No Measles
Yes No Mumps
Yes No Rubella
Yes No Chickenpox
Yes No Smallpox
Yes No Scarlet Fever
Yes No Whooping Cough
Yes No Tuberculosis
Yes No Herpes, oral
Yes No Herpes, genital
Yes No Sexually Transmitted Infection/s
Yes No Hepatitis
Yes No Mononucleosis
Yes No Malaria
Yes No Meningitis

Additional Medical History
Yes No Cancer ________________________
Yes No Unusual fatigue
Yes No Frequent colds
Yes No Skin disorder/infections
Yes No Recent gain or loss of weight
Yes No Fevers for unknown reason
Yes No Hospitalizations
Yes No Surgeries
Yes No Other _____________________

Provider Review:
____

Please explain all affirmative (Yes) answers and explain conditions you are or have been subject to that are not listed above:
____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Print name: _____________________________ **Signature:** _____________________________ **Date:** __________

Current physicians/healthcare providers:

Name:______________________________Type of Practice: ______________________

Phone:______________________________

Name:______________________________Type of Practice: ______________________

Phone:______________________________
Name:______________________________Type of Practice: ______________________

Phone:______________________________

Please list all medications that you are currently taking (prescription and non-prescription). Include dosages when possible:

____

____
____

Medications you have taken in the past:
____

____

List all supplements (vitamins, minerals, herbs, enzymes, food concentrates, you are currently taking. Include dosage if possible:

____

____
____

Supplements taken in the past: ______________________________________

____
____

Other hormonal disorders not previously noted: ______________________________
____

Other health related conditions not previously noted: __________________________
____
____

Family Medical History (please note any serious health conditions in your immediate family):

Mother______________________ Mother's Mother ______________________

Mother's Father ____

Father______________________ Father's Mother ______________________

Father's Father ____

Siblings ____

Children (pregnancies, births, miscarriages, abortions): ______________________
____

Lifestyle

Please describe your food and drink intake in the past 24 hours in as much detail as possible:

Breakfast

Lunch

Dinner

Snacks
Beverages
Caffeine intake – what and how often?

Soft drink or carbonated beverage intake – what and how often?
Consumption of candy – how often?
Use of artificial sweeteners – what and how often?
Recreational drug use – what and how often?
Alcohol intake – what kind and how many drinks per week?
Tobacco use – how often?
Number of bowel movements per day?
How many hours of sleep per night? Do you feel rested upon rising?
Rate your average energy level if 1 is lowest and 10 is highest
Stress level: ____ low ____ medium ____ high
Do you feel that stressors in your life are manageable?
Do you have a support system that is working for you?
Work/profession:
Spiritual practices:
Interests:
Is there anything else that you would like Dr. Lamothe to know about you?

Doctor's Notes:

Doctor Review:

Christa Lamothe, N.D.