

Today's Date \_\_\_\_\_

## **PATIENT REGISTRATION**

NAME: \_\_\_\_\_  
(Last) (First) (Middle)

ADDRESS: \_\_\_\_\_  
(Street)

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

MARITAL STATUS: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

SOCIAL SEC NO: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_

HOME PH: \_\_\_\_\_ WORK PH: \_\_\_\_\_ CELL PH: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ WORK PH \_\_\_\_\_

WHO IS YOUR FAMILY DOCTOR? \_\_\_\_\_

HAS DR. CRITCHLOW SEEN ANY OF YOUR FAMILY MEMBERS? \_\_\_\_\_

IF SO, NAME & RELATIONSHIP \_\_\_\_\_

WHO REFERED YOU TO DR. CRITCHLOW? \_\_\_\_\_

### **AUTHORIZATIONS**

I hereby authorize Dr. Critchlow to furnish information to insurance carriers and referred physicians concerning my illness and treatment.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

I hereby authorize my insurance benefits to be paid directly to J. Thomas Critchlow, M.D. I understand I am financially responsible for all charges.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

### **Insurance Information**

Name of Insurance Company \_\_\_\_\_

ID # \_\_\_\_\_ Group \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ **AND** Social Sec# \_\_\_\_\_

# MEDICAL HISTORY

PLEASE LIST ALL TIMES YOU HAVE BEEN HOSPITALIZED, GIVE DATES AND REASONS FOR HOSPITALIZATION(S):

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PLEASE LIST ALL OPERATIONS YOU HAVE HAD IF NOT DESCRIBED ABOVE AND GIVE DATES IF POSSIBLE:

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ARE YOU ALLERGIC TO ANYTHING? (DRUGS, FOOD, ANIMALS) \_\_\_\_\_

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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN RECENTLY:

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DO YOU SMOKE? \_\_\_\_\_ YES \_\_\_\_\_ NO IF SO, HOW MANY PACKS/DAY? \_\_\_\_\_

FOR APPROXIMATELY HOW LONG? \_\_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_ YES \_\_\_\_\_ NO IF SO, HOW OFTEN PER WEEK? \_\_\_\_\_

## FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING?

HEART DISEASE \_\_\_\_\_ STROKE \_\_\_\_\_ CANCER \_\_\_\_\_ DIABETES \_\_\_\_\_

HEREDITARY DISEASE \_\_\_\_\_ OTHER \_\_\_\_\_

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## PERSONAL HISTORY

PLEASE CIRCLE

### **HEENT**

### EXPLAIN

YES NO

EAR PROBLEMS \_\_\_\_\_

YES NO

SPELLS OF BLURRED VISION \_\_\_\_\_

YES NO

RECURRENT SORE THROATS \_\_\_\_\_

YES NO

PERSISTENT HOARSENESS \_\_\_\_\_

YES NO

DIFFICULTY SWALLOWING \_\_\_\_\_

YES NO

ENLARGED GLANDS \_\_\_\_\_

YES NO

THYROID PROBLEMS \_\_\_\_\_

YES NO

SINUS PROBLEMS \_\_\_\_\_

YES NO

GLAUCOMA \_\_\_\_\_

YES NO

CATARACTS \_\_\_\_\_

YES NO

FREQUENT HEADACHES \_\_\_\_\_

YES NO

DIZZINESS \_\_\_\_\_

YES NO

OTHER EYE PROBLEMS \_\_\_\_\_

### **PULMONARY**

YES NO

COUGH UP BLOOD \_\_\_\_\_

YES NO

DO YOU COUGH UP MUCOUS? IF SO, WHAT? \_\_\_\_\_

YES NO

CHRONIC COUGH \_\_\_\_\_

YES NO

CHEST PAIN \_\_\_\_\_

YES NO ANY CHRONIC LUNG DISEASE? EMPHYSEMA, BRONCHITIC OR  
ASTHMA? \_\_\_\_\_  
YES NO SHORTNESS OF BREATH \_\_\_\_\_

**MUSCULOSKELETAL**

YES NO BACK OR NECK PAIN \_\_\_\_\_  
YES NO ARTHRITIS \_\_\_\_\_  
YES NO BROKEN BONES \_\_\_\_\_

**CORONARY**

YES NO HISTORY OF HEART ATTACK OR DISEASE \_\_\_\_\_  
YES NO HIGH BLOOD PRESSURE \_\_\_\_\_  
YES NO FLUTTERING OR PALPITATIONS OF HEART \_\_\_\_\_  
YES NO HISTORY OF BLOOD CLOT IN LEGS, PAIN IN LEG FEET OR HIPS  
AFTER WALKING THAT IS RELEIVED BY REST? \_\_\_\_\_  
YES NO AWAKENED AT NIGHT WITH PAIN IN FEET \_\_\_\_\_  
YES NO HISTORY OF STROKE \_\_\_\_\_  
YES NO VARICOSE VEINS \_\_\_\_\_  
YES NO COOLNESS OF FEET \_\_\_\_\_  
YES NO HISTORY OF TEMPORAY LOSS OF STRENGTH OF EXTREMITIES,  
LOSS OF FEELING, SLURRED SPEECH \_\_\_\_\_  
YES NO TINGLING AROUND MOUTH, OR BLURRED VISION IN ONE EYE  
\_\_\_\_\_  
YES NO ULCERS OR SORES ON FEET OR LEGS \_\_\_\_\_

**GASTROINTESTINAL**

YES NO HISTORY OF ULCER DISEASE \_\_\_\_\_  
YES NO HISTORY OF GALLBLADDER DISEASE \_\_\_\_\_  
YES NO HISTORY OF COLON/BOWEL DISEASE \_\_\_\_\_  
YES NO HISTORY OF LIVER DISEASE OR HEPATITIS \_\_\_\_\_  
YES NO HISTORY OF YELLOW JAUNDICE \_\_\_\_\_  
YES NO HISTORY OF RECTAL DISEASE OR HEMORRHOIDS \_\_\_\_\_  
YES NO VOMIT BLOOD \_\_\_\_\_  
YES NO ABDOMINAL PAIN \_\_\_\_\_  
YES NO IS ABDOMINAL PAIN RELATED TO FOOD? \_\_\_\_\_  
YES NO CHANGE IN CALIBER, COLOR, FREQUENCY OF STOOL \_\_\_\_\_  
YES NO BLACK STOOL \_\_\_\_\_  
YES NO HISTORY OF HERNIA \_\_\_\_\_  
YES NO HISTORY OF ANEMIA \_\_\_\_\_  
YES NO FREQUENT CONSTIPATION OR DIARRHEA \_\_\_\_\_  
YES NO DO YOU FOLLOW A SPECIAL DIET AT HOME? \_\_\_\_\_  
YES NO ARE THERE ANY FOODS YOU CANNOT EAT? \_\_\_\_\_  
YES NO HAVE YOU LOST OR GAIN WEIGHT RECENTLY? \_\_\_\_\_  
IF SO, HOW MUCH? \_\_\_\_\_

**G.U.**

YES NO BURNING WITH URINATION \_\_\_\_\_  
YES NO DIFFICULTY STARTING TO URINATE \_\_\_\_\_  
YES NO LOSE URINE WITH COUGH OR STRAINING \_\_\_\_\_  
YES NO HISTORY OF BLADDER OR KIDNEY INFECTIONS \_\_\_\_\_  
YES NO HISTORY OF OTHER RENAL DISEASE \_\_\_\_\_  
YES NO BLOOD IN URINE \_\_\_\_\_

YES NO

FREQUENTLY WAKE UP AT NIGHT TO PASS URINE OR URINATE  
\_\_\_\_\_

**FEMALES ONLY**

YES NO

CURRENTLY HAVING A PERIOD? IF SO, DATE OF LAST \_\_\_\_\_

YES NO

ARE PERIODS REGULAR? \_\_\_\_\_

YES NO

VAGINAL DISCHARGES \_\_\_\_\_

YES NO

BREAST MASSES \_\_\_\_\_

YES NO

BREAST BIOPSIED OR ASPIRATED. \_\_\_\_\_ IF SO, EXPLAIN  
\_\_\_\_\_

YES NO

CHILDREN? \_\_\_\_\_ IF SO, WHAT AGES \_\_\_\_\_

MEANS OF CONTRACEPTION \_\_\_\_\_