PREMIER *medical group*

INSTRUCTIONS

Page 1 - *Patient Registration Form* - fill out entire page and sign at bottom of page.

Page 2 - Complete *Records Release Form* as required for your upcoming office visit.

Page 3 – Complete the *Health History Questionnaire* (per specialty).

Bring all paperwork, filled out, to your scheduled appointment along with:

- Medical insurance and prescription cards
- Any recent labs or radiology workups
- Picture ID
- List of medications

If your insurance requires a referral, you must bring it with you at the time of service or you will be required to sign a waiver holding you responsible.

NO SHOW POLICY

A FEE MAY BE CHARGED TO ANY PATIENT WHO DOES NOT CANCEL THEIR OFFICE VISIT WITHIN 24 HOURS AND WILL BE CHARGED FOR ANY NO SHOW FOR AN OFFICE PROCEDURE.

CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE

PREMIER *medical group*

Comprehensive Patient History

Patient Name:_____ Date of Birth:_____ Date_____

What is the reason for today's visit?_____

_____

Describe the following

Who referred you here today?_____

How long have you had this problem?_____

How severe is this problem? __Mild __ Moderate __Severe How often are you having this problem _____

What caused the problem?_____

Do you know of anything that may have contributed to this problem?_____

Does anything else occur with this problem?_____

Additional Comments:_____

List Previous hospitalizations/Surgeries/Serious Injuries	When?	List any allergies you have
_____	_____	1)_____
_____	_____	2)_____
_____	_____	3)_____
_____	_____	4)_____
_____	_____	5)_____
_____	_____	6)_____
_____	_____	7)_____
_____	_____	8)_____

Patient Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously but quit ☐ Current packs per day____

Use of drugs: ☐ Never ☐ Type/frequency_____

Last Tetanus_____

Have you ever had the following?							
Cancer.....	yes	no	Convulsions.....	yes	no	Hypertension.....	yes	no
Arthritis/Gout.....	yes	no	Diabetes.....	yes	no	Heart Trouble.....	yes	no
Acute Infections.....	yes	no	Stroke.....	yes	no	Bleeding Tendency.....	yes	no
			Venereal Disease.....	yes	no	Hereditary Defects.....	yes	no

Family Medical History

	Age	Diseases	If deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING IN THE PAST THREE MONTHS? **CIRCLE YES ANSWERS ONLY!**

CONSTITUTIONAL **DATE**

Good general health lately..... NO .....YES
Recent weight changes ..... NO .....YES
Fever ..... NO .....YES
Headaches ..... NO .....YES

EYES

Eye disease or injury .....NO.....YES
Wear glasses/contact lenses .....NO .....YES
Blurred vision or double vision .....NO .....YES
Glaucoma ..... NO .....YES

ENT

Hearing loss .....NO.....YES
Ringing in ears .....NO.....YES
Earaches or drainage .....NO.....YES
Sinus problems.....NO.....YES
Nose bleeds ..... NO.....YES
Mouth sores .....NO.....YES
Bleeding gums .....NO.....YES
Bad breath or bad taste ..... NO.....YES
Sore throat or voice change..... NO.....YES
Swollen glands in neck ..... NO .....YES

CARDIOVASCULAR

Heart trouble.....NO.....YES
Chest pains .....NO .....YES
Sudden heart beat changes .....NO .....YES
Swelling of feet, ankles, or hands.....NO .....YES

RESPIRATORY

Frequent coughing .....NO .....YES
Spitting up blood .....NO .....YES
Shortness of breath .....NO .....YES
Asthma or wheezing .....NO .....YES

GASTROINTESTINAL

Loss of appetite .....NO .....YES
Change in bowel movements .....NO .....YES
Nausea or vomiting .....NO .....YES
Frequent diarrhea .....NO .....YES
Painful bowel movement or constipation ....NO .....YES
Blood in stool .....NO .....YES
Stomach pain .....NO .....YES

GENITOURINARY

Frequent urination .....NO .....YES
Burning or painful urination .....NO .....YES
Blood in urine .....NO .....YES
Change of force of strain when urinating .....NO .....YES
Incontinence or dribbling .....NO .....YES
Kidney Stones .....NO .....YES
Male-testicle pain .....NO .....YES
Female-pain with periods .....NO .....YES
Female-#pregnancies_____ #miscarriages_____

MUSCULOSKELETON **DATE**

Joint pain.....NO .....YES
Joint stiffness.....NO .....YES
Weakness or swelling .....NO .....YES
Muscle pain or cramps .....NO .....YES
Back pain.....NO .....YES
Cold extremities.....NO .....YES
Difficulty .....NO .....YES

SKIN

Rash or itching.....NO .....YES
Change in skin color.....NO .....YES
Change in hair or nails .....NO .....YES
Varicose veins .....NO .....YES
Breast pain .....NO .....YES
Breast lump ..... NO .....YES
Breast discharge ..... NO .....YES

NEUROLOGICAL

Frequent or recurrent headaches...NO ...YES
Light headed or dizziness .....NO ...YES
Convulsions or seizures .....NO ...YES
Tremors .....NO ...YES
Paralysis .....NO ...YES
Stroke .....NO ...YES

PSYCHIATRIC

Memory loss.....NO .....YES
Nervousness.....NO .....YES
Depression.....NO .....YES
Sleep problems .....NO .....YES

ENDOCRINE

Glandular or hormone problem NO.....YES
Thyroid disease .....NO .....YES
Excessive thirst or urination.....NO.....YES
Heat or cold intolerance .....NO ....YES
Dry skin .....NO .....YES
Change in hat or glove size .....NO ....YES

Patient Signature_____

Provider Signature _____