CALDERA
family medicine

Registration Form

PATIENT INFORMATION				
Last Name:	First:	Middle:	Date of Birth:	Sex: □ M □ F □ O
Is this your legal name? □ Yes □ No	Former Name:	Marital Status:	Social Security #	
Phone Number:	Email Address:		Ok to Web Enable? □ Yes □ No	
Street Address:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer Phone #		
Primary Insurance Name:	Policy #:	Group #:		
Secondary Insurance Name:	Policy #	Group #:		
Preferred Pharmacy:	Pharmacy Location:			
How did you hear about us?				

RACE	**ETHNICITY**	**PREFERRED LANGUAGE**
□ American Indian or Alaska Native	□ Hispanic	□ English
□ Asian	□ Non-Hispanic/Non-Latino	□ Spanish
□ Native Hawaiian, Pacific Islander	□ Other _____	□ Other _____
□ Black or African American		
□ White or Caucasian		
□ Other _____		

IN CASE OF EMERGENCY		
Name:	Relation:	Phone:

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HEALTH HISTORY QUESTIONNAIRE

(All questions contained in this questionnaire are strictly confidential and will become part of your medical record)

Patient Name:

MEDICATIONS		
Name of the Drug	Strength	Frequency Taken

LIST ANY PREVIOUS MEDICAL DIAGNOSIS

ALLERGIES	
Name of drug, food or item	Reaction

SURGERIES		
Year	Reason	Hospital

OTHER HOSPITALIZATIONS		
Year	Reason	Hospital
Have you ever had a blood transfusion?	□ Yes □ No	

FAMILY HEALTH HISTORY		**Significant Health History**
Father	Age	
Mother	Age	

Siblings	□ M □ F	
	□ M □ F	
	□ M □ F	
Children	□ M □ F	
	□ M □ F	
	□ M □ F	
Grandmother (Maternal)	Age	
Grandfather (Maternal)	Age	
Grandmother (Paternal)	Age	
Grandfather (Paternal)	Age	

HEALTH HABITS AND PERSONAL SAFETY

EXERCISE	□ Sedentary (No exercise) □ Mild exercise (i.e. climb stairs, walk 3 blocks, golf) □ Occasional vigorous exercise (i.e. work or recreation, less than 3x weekly for 30 min) □ Regular vigorous exercise (i.e. work or recreation 4x weekly or more for 30 min)			
DIET	Are you dieting? □ Yes □ No **|** If yes, are you on a physician prescribed diet? □ Yes □ No			
	Rank of salt intake	□ High	□ Medium	□ Low
	Rank of fat intake	□ High	□ Medium	□ Low
CAFFEINE	□ Coffee	□ Tea	□ Cola	□ Other: _____
SEX	Are you sexually active? □ Yes □ No			
	Do you have sex with Men? Women? Both? (check all that apply) □ Men □ Women			
	How many partners have you had in the last 3 months? _____ One year? _____			
	Any discomfort with intercourse? □ Yes □ No			
	Illness related to HIV, has become a public health problem. Risk factors for this illness include IV drug use and unprotected sexual intercourse. Would you like to discuss this today? □ Yes □ No			
PERSONAL SAFETY	Do you live alone? □ Yes □ No			
	Do you have frequent falls? □ Yes □ No			
	Do you have vision or hearing loss? □ Yes □ No			
	Do you have an advanced directive and/or living will? □ Yes □ No			
	Would you like information on the preparation of these? □ Yes □ No			
	Physical and/or mental abuse are also a major public health issue. This often takes the form of verbally threatening, sexual or physical abuse. Would you like to discuss this today? □ Yes □ No			