Murray & Associates Family Healthcare

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PATIENT REGISTRATION INFORMATION

Today's Date: _____

Name:

Last: _____ First: _____ Middle: _____

Address:

_____

Social Security No.: **Date of Birth:** **Age:** **Sex:**

_____ _____ _____ _____/_____/_____ _____ M or F

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity:
☐ Hispanic ☐ Non-Hispanic

Language(s) Spoken:
_____

Contact Information:

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

INSURANCE INFORMATION

Subscriber Name:
_____

Patient relationship to subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber SSN: _____ _____ _____

Group Number: _____

Subscriber Birth Date: _____ / _____/ _____

Policy Number: _____

Secondary Insurance (if applicable):

_____

Name:_____ DOB: ___/_____/___

Do you have Advanced Directives?

Living Will: □ Yes □ No Durable Power of Attorney : □ Yes □ No
Do you have a copy of these documents at visit? □ Yes □ No

ALLERGIES: _____

CURRENT MEDICATIONS
List all medications including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken.

_____
_____
_____

Dates of last immunization?

Tetanus : _____
Influenza : _____
Pneumococcal : _____

Prevnar 13 : _____
Zostavax (Shingles): _____

Born between 1946-1964? □ Yes □ No

PERSONAL MEDICAL HISTORY: (Please check all that apply)

□ ADHD	□Diabetes: Type 1 or 2 Insulin	□Liver Disease
□ Alcoholism	□Dependent? Y or N	□Macular Degeneration
□ Allergies, Seasonal	□Diverticulosis/Diverticulitis	□Neuropathy
□ Anemia	□DVT (Blood Clot)	□Osteopenia/Osteoporosis
□ Anxiety	□GERD (Acid Reflux)	□Parkinson's Disease
□Arrhythmia (irregular heart beat)	□Glaucoma	□Peripheral Vascular Disease
□Arthritis	□Hiatal Hernia	□Peptic Ulcer
□Asthma	□High Blood Pressure	□Psoriasis
□Bipolar	□Heart Attack (MI)	□Pulmonary Embolism (PE)
□Bladder Problems / Incontinence	□Heart Disease	□Rheumatoid Arthritis
□Bleeding Problems	□Kidney Stones	□Seizure Disorder
□Cancer: _____	□Kidney Disease	□Sleep Apnea
□Headaches	□High Cholesterol	□Stroke
□Crohn's Disease	□HIV	□Thyroid Disorder
□COPD/ Emphysema	□Hepatitis	□Ulcerative Colitis
□Dementia	□Irritable Bowel Syndrome	
□Depression	□Lupus	

Last Menstrual Period	Date: _____		Normal / Abnormal
Colonoscopy	□ **Yes** □ **No**	Date: _____	Normal / Abnormal
Mammogram	□ **Yes** □ **No**	Date: _____	Normal / Abnormal
Dexa (Bone Density)	□ **Yes** □ **No**	Date: _____	Normal / Abnormal
Pap	□ **Yes** □ **No**	Date: _____	Normal / Abnormal

Name:_____ DOB: ___/_____/___

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL / CULTURAL HISTORY

Education Level: ☐ **Elementary** ☐ **High School** ☐ **Vocational** ☐ **College** ☐ **Graduate / Professional** ☐ **Yes** ☐ **No**

Are there any vision problems that affect your communication? ☐ **Yes** ☐ **No**

Are there any hearing problems that affect your communication? ☐ **Yes** ☐ **No**

Are there any limitations to understanding or following instructions? (either written or verbal)? ☐ **Yes** ☐ **No**

Current Living Situation: (check all that apply) ☐ **Single Family** ☐ **Multi-generational** ☐ **Vocational** ☐ **Homeless Household** ☐ **Shelter** ☐ **Skilled Nursing Facility**

Tobacco Use: ☐ Current ☐ Past ☐ Never Type :_____ Amount/day : _____ Years : _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/per week:_____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Caffeine ☐ Soda ☐ Coffee # Cans per day: _____ # Cups per day: _____

Exercise:
☐ Sedentary (no exercise) ☐ Mild exercise (i.e. walk, climb stairs)
☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week, 30 minutes)
☐ Vigorous exercise (i.e. work or recreation more than 4x/week, 30 minutes)

Are you sexually active? ☐ **Yes** ☐ **No**

Name:_____ DOB: ___/_____/___

FAMILY HISTORY: (Please check all that apply)

FATHER

Living Age : _____
Deceased Age : _____

□ Alcoholism
□ Anemia
□Arthritis
□Asthma
□Bipolar
□Cancer: _____
□COPD/ Emphysema
□Dementia
□Depression
□Diabetes: Type 1 or 2 Insulin
□DVT (Blood Clot)
□Heart Disease
□Kidney Disease
□Migraines
□ Osteoporosis
□Stroke
□Thyroid Disorder

□Other:
_____

MOTHER

Living Age : _____
Deceased Age : _____

□ Alcoholism
□ Anemia
□Arthritis
□Asthma
□Bipolar
□Cancer: _____
□COPD/ Emphysema
□Dementia
□Depression
□Diabetes: Type 1 or 2 Insulin
□DVT (Blood Clot)
□Heart Disease
□Kidney Disease
□Migraines
□ Osteoporosis
□Stroke
□Thyroid Disorder

□Other:
_____

SIBLINGS
Please indicate any illnesses your siblings have or had which are listed in this section.

_____

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Ophthalmologist, Psychiatrist, Therapist, Kidney Specialist, Dentist, etc.)

_____
_____
_____

Patient Signature: _____ Date: _____

_____ Date: _____
Signature of Reviewing Provider