# Salem Family Medicine Patient Registration

Please be advised that completing preliminary health insurance questionnaires does not establish a physician-patient relationship with this practice. The doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Patient Name: _____

Address:_____

City: _____ State:_____ Zip:_____

Birth Date:_____ Email: _____

Phone _____Work Phone: _____ Cell Phone: _____

SSN: _____ Pharmacy (& location): _____

Race: _____ Ethnicity: Hispanic Non-Hispanic Language: _____

Emergency Contact:

(Name) _____ (Relationship) _____ (Phone) _____

How did you hear about our clinic? _____

If internet, what site?: _____

**Responsible Party (if different from above)**:

Name: _____

Address:_____

SSN:_____ DOB:_____

Phone _____

**Primary Insurance Plan:**

Name: _____ ID# _____ Group # _____

**Secondary Insurance Plan:**

Name: _____ ID# _____ Group # _____

**SALEM FAMILY MEDICINE**
**ADULT HEALTH HISTORY FORM**

**Name:** _____ **Date:** _____
**Previous Doctor:** _____
**Medications** (prescriptions & non-rx)**:**

_____
_____
_____
_____
_____

**Allergies to medications:** __no __yes
If yes, list: _____

**Health Maintenance:** When were your last shots:
Tetanus (Td) _____ Pneumovax _____
Last cholesterol _____ results _____
Colon screening (scope) _____ results _____

**For women:**
Pap smear _____ ever abnormal? __no __yes
Mammogram _____ ever abnormal? __no __yes
Bone density _____ ever abnormal? __no __yes
Do you get your women's health care elsewhere?:
__no __yes If so, where: _____
Bleeding between periods or with sex? __no __yes
Any concerns about your periods? __no __yes
Any bleeding after menopause? __N/A __no __yes

**Personal Medical History** Have you ever had (check):

__Allergies/hayfever
__Anemia
__Arthritis
__Asthma
__Bleeding problem
__Breast disease
__Cancer, type:_____
__Depression/Mental prob
__Diabetes
__Heart disease
__High blood pressure
__Kidney disease
__Liver disease
__Lung problems
__Rheumatic fever
__Significant injury
__Stroke
__Substance abuse
__Thyroid problem
__Ulcers

Other significant problems & details of positive responses:
_____
_____
_____
_____

**Surgeries:** Please list all prior Surgeries and dates:

_____
_____

Have any **Immediate Family Members** had:

__Alcohol/substance abuse
__Anesthesia problem
__Asthma
__Autoimmune disorder
__Bleeding problem
__Cancer, breast
__Cancer, colon
__Cancer, melanoma
__Cancer, prostate
__Cancer, ovary
__Cancer, other type: _____
__Depression/Mental prob
__Diabetes
__Heart disease
__High blood pressure
__High cholesterol
__Kidney disease
__Osteoporosis
__Stroke
__Thyroid problem

Other significant problems:
_____
_____
_____
_____



**Social History: Habits:**
Smoking: currently__ never__ year quit _____
If current or past: packs/day _____ # years _____
Other tobacco? __pipe __cigar __snuff __chew
Alcohol Use: __ no __ yes: # drinks/week _____

In the past year have you ever had 4 or more drinks in one day (1=12oz beer, 5oz wine, 1.5oz liquor)?__no __yes
In the past year have you ever used a recreational drug, or used a rx med for non-medical reasons? __no __yes

Have you ever used needles? __no __yes
Is gambling a concern for you or others? __no __yes
If you are sexually active, do you have 1 faithful partner or use safer sex methods __yes __no
Do you eat a balanced low fat diet? __yes __no
Do you exercise regularly? __yes __no
**Safety:** Do you use a bike helmet? __yes __no
Do you always use seatbelts? __yes __no
Is violence at home a concern for you? __no __yes
Have you ever been abused? __no __yes
Is there a gun in your home? __no __yes
If so, is it locked apart from ammunition? __yes __no
**Home and work:** Occupation: _____
Marital status: S__ M__ D__ W__ Other:_____
Spouse/partner's name: _____
Spouse/partner's occupation: _____
Ages of children: _____
Who lives at home with you? _____
_____
Religious preference: _____
Hobbies/interests: _____

**Review of Symptoms:** Are you having:

Constitutional
__Fevers/chills/sweats
__Unexplained weight chg
__Excess thirst or urination
Eyes/Ears/Nose/Throat
__Change in vision
__Difficult hearing/ringing
__Hay fever/allergies
Chest
__Chest pain/discomfort
__Palpitations
__Difficulty breathing
__Cough/wheeze
__Breast lump
__Nipple discharge
Gastrointestinal
__Abdominal pain
__Blood in bowel movement
__Nausea/vomiting/diarrhea
Genitourinary
__Leaking urine
__Unusual vaginal bleeding
Muscle/Joint/ Skin
__Muscle/joint pain
__Rash/mole change
__Unexplained lumps
__Easy bruising/bleeding
Neurological
__Headaches
__Dizziness/light-headed
__Numbness/tingling
__Memory loss
__Loss of coordination
__Sleep problems
In past 2 weeks have felt:
__down/depressed/hopeless
__little interest or pleasure in doing things

Other current concerns: _____

_____
_____
_____
_____
_____
_____