Cornerstone Medical Associates, PLLC.

Registration Form

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First name:	Middle name:	Marital Status: Single__ Married___ Widowed____

Is this your legal name? O Yes O No	If not, what is your legal name?	Former name:	DOB:	Age:	Sex: O M O F

Address:[Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by: _____

Other family members seen here: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill: Self___ Insurance__ Other___	Birth Date:	Address(if different):	Home phone no. (if different):

Is this person a patient here? O Yes O No	Is this patient covered by insurance? O Yes O No

Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	DOB:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: [Choose item] | Other: [Relationship to subscriber]

Name of secondary insurance(if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CORNERSTONE MEDICAL ASSOCIATES or insurance company to release any information required to process my claims.

_____ _____

Parent/Guardian signature Date

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CORNERSTONE MEDICAL ASSOCIATES
Adult Medical History Form

NAME: _____ **D.O.B**_____

EMAIL: _____

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

Thank you!

PRESENT HEALTH CONCERNS:

_____
_____
_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

MEDICATIONS	DOSE AND TIME PER DAY

ALLERGIES or REACTION TO MEDICINES/FOOD/OTHER AGENTS

MEDICATION	REACTION or SIDE EFFECT

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PERSONAL MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

__Congenital Heart Disease: Specify type_____
__ Myocardial Infarction (Heart Attack)
__Hypertension (High Blood Pressure)
__Diabetes
__High Cholesterol
__Stroke
__Thyroid problem: Specify type_____
_____
__Coagulation (bleeding/clotting) disorder
__Cancer (Malignancy): Specify type_____
__Depression/suicide attempt
__Alcoholism
__If you have ever had a blood transfusion, please specify date_____
__Abnormal Pap smear; if yes when?
_____
_____
Other_____
_____
_____
When was your last Tetanus shot?
_____
_____

SURGICAL HISTORY (Please list all prior operations and dates):

OPERATION	DATE

SOCIAL HISTORY:

__Substances: Specify type_____
_____
__Tobacco Use: __Cigarettes __Pipe __Cigar __Snuff __Chew
___Never
___Current Smoker: packs/day___ #of yrs.___
Are you interested in quitting? ___No __Yes
Quit:
Date_____
Who lives at home with you? _____
_____
____

SOCIOECONOMICS:

Occupation: _____
Education completed: __Grade School __High School __College __Graduate School ___Years of Education
Marital Status: __Single __M __Sep __D __W
Spouse/Partner's name: _____
Number of children: _____

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SEXUALITY

Sexual Activity

Sexually Active: __Yes __No

Current sex partner(s) is/are: __Male __Female

Contraception and Protection

Birth Control Method: _____

If sexually active, do you practice safe sex? __NA __No __Yes

Have you ever had any sexually transmitted diseases (STDs)? __No __Yes

If yes, please include:

_____
_____
_____
_____
_____

ALCOHOL USE

Do you drink alcohol? __NO __Yes: drinks/week__

Is alcohol use a concern for you or others? __No __Yes

DRUG USE

Do you use any recreational drugs? __No __Yes

Have you ever used needles __No __ Yes

EXERCISE

Do you exercise regularly? __No __Yes

Are you interested in being screened for sexually transmitted diseases? __YES __NO

Other concerns?

_____
_____

SAFETY:

Do you use seat belts consistently? __No __Yes

Do you use a bike helmet regularly? __No __ Yes

Is violence at home a concern for you? __No __Yes

Do you feel safe in your current relationship? __No __Yes

Do you have a gun in your home? __No __Yes

Other concerns?

_____
_____

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? __No __Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? __No __Yes
3. Have you felt depressed or sad most of the time in the past year? __No __Yes

IMMUNIZATIONS

Please list your most recent immunizations. Please include your best estimate of the month and year of each immunization:

Hepatitis A_____ Measles_____ Mumps_____ Rubella_____ Pneumonia_____

Hepatitis B____ MMR____ Tetanus (Td)____ Varicella(chicken pox) shot____

Other_____

REVIEW OF SYSTEMS: Please check any current problems you have on the list below.

Constitutional
__Fevers/chills/sweats
__Unexplained weight loss/gain
__Fatigue/weakness
__Excessive thirst or urination

Eyes
__Change in vision

Ear/Nose/Throat/Mouth
__Difficult hearing/ringing in ears
__ Problems with teeth/gums
__Hay fever/allergies

Cardiovascular
__Chest pain/discomfort
__Leg pain with exercise
__Palpitations

Chest (breast)
__Breast lumps/discharge

Respiratory
__Cough/wheeze
__Difficulty breathing

Gastrointestinal

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__Abdominal pain
__Blood in bowel movement
__Nausea/vomiting/diarrhea

Genitourinary

__Nighttime urination
__Leaking urine
__Unusual vaginal bleeding
__Discharge: penis or vagina
__Sexual functions problems

Musculo-skeletal

__Muscle/joint pain

Skin

__Rash or mole change

Neurological

__Headaches
__Dizziness/light-headedness
__Numbness
__Memory loss
__Loss of coordination

Psychiatric

__Anxiety/stress
__Problems with sleep
__Depression

Blood/Lymphatic

__Unexplained lumps
__Easy bruising/bleeding

Other (please specify)_____
_____
____

WOMEN'S GYNECOLOGIC HISTORY:

For Women: #pregnancies: ___#deliveries: ___#abortion: ___ #miscarriages: ___
1st day, most recent period: ___ __Age at 1st period:___ __Frequency of periods:_____ Length of each:_____
Do you have any concerns about your periods? ____No ____Yes:_____
Do you have any concerns about menopause? _____No ____Yes:_____

FAMILY HISTORY

Please indicate with a check family members who have had any of the following condition:

MEDICAL CONDITION	MOM	DAD	SIS	BRO.	DAUG	SON	OTHER
ALCOHOLISM							
ANEMIA							
ANESTHESIA PROBLEM							
ARTHRITIS							
ASTHMA							
BIRTH DEFECTS							
BLEEDING PROBLEM							
CANCER, BREAST							
CANCER, COLON							
CANCER, MELANOMA							
CANCER, SKIN							
CANCER, OVARY							
CANCER, PROSTATE							
CANCER (not noted)							
DEPRESSION							
DIABETES, TYPE 1							
DIABETES, TYPE 2							
ECZEMA							
EPILEPSY (SEIZURES)							
GENETICS DISEASES							
GLAUCOMA							
HAY FEVER (ALLERGIC RHINITIS)							
HEARING PROBLEMS							
HEART ATTACK (CORONARY HEART DISEASE)							
HIGH BLOOD PRESSURE (HYPERTENSION)							
HIGH CHOLESTEROL (HYPERLIPIDEMIA)							
KIDNEY DISEASES							
LUPUS (SYSTEMIC LUPUS							

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ERYTHEMATOSIS)							
MENTAL RETARDATION							
MIGRAINE HEADACHES							
MITRAL VALUE PROLAPSE							
OSTEOARTHRITIS							
OSTEOPOROSIS							
RHEUMATOID ARTHRITIS							
STROKE							
THYROID DISORDERS							
TUBERCULOSIS							
OTHER:							

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