Repeat Patient Registration

Last Name:	First:	Middle Initial:	Date of Birth:

Social Security #:	Gender:	Marital Status: **M/S/D/W**	Race:	Ethnicity:

Mailing Address:	City:	State:	Zip Code:

Home Telephone #:	Mobile Telephone #:

Emergency Contact: Name:	Phone #: Relationship to patient:

Email:	Preferred Language:	Do you need an Interpreter?

Preferred Pharmacy:	Pharmacy Location:	Primary Care Physician:

Reason for Todays Visit:

Is this a Work-Related Injury?

Employer Name:	Employer Contact:

Patient Medical History

Any foreign travel in the last 60 days? **Y/N** If yes, where?
Zika/Ébola exposure? **Y/N**

Current Medications Including supplements

Current Medication Name	Dose and Frequency	Reason for Use

Medication you are allergic to:	**Type of reactions to drug allergies:**

Surgical History

Any surgeries since your last visit?

Social History

Occupation:		Highest level of Education: **HS/AAS/BS/MA/DR**
Do you have a disability? **Y/N**		If yes please specify:
Do you exercise? **Y/N**		How Often?
Do you feel safe in your environment? **Y/N**		
Tobacco Use: **Chew/Snuff:** Never Current Use per day: #of yrs: Quit: When?	**Alcohol Consumption:** How Often? How Many? # of yrs:	**Recreational Drug use: Y/N** Type?
Are you sexually active? **Y/N** □Heterosexual □Bisexual □Homosexual		Contraception/Protection Use? **Y/N** Type: Sexually transmitted disease:

Family Medical History

Does your Mother, Father, Siblings or Children have any Medical Issues? (Please list and Specify)

Medical Screenings

Please specify any recent test related to your visit today:

Ob/Gyn History (Female patients)

Last Menstrual Period: / / Are you pregnant? **Y/N**	Are you trying to become pregnant? **Y/N**
Are You Breast feeding? **Y/N**	C-Sections? **Y/N #:**

Thank you for your time and patience in completing this form. This information you provided will assist us with your diagnosis and determining your medical treatment. Please sign below to indicate that you have filled out the form to the best of your ability.

Patient Signature: _____Date: _____

Patient Representative (Print Name): _____Relationship to Patient: _____