HILL PARK MEDICAL CENTER
PATIENT REGISTRATION FORM

Name: ______________________________ Date: __________

Address: ______________________________

City: ______________________________ State: ______ Zip: __________

Contact: ______________________________

Home Phone: ______________ Work: ______________ Cell: ______________

Email: ______________________________

Date of Birth: ______________ Age: __________ Gender: ______________

SSN#: ______________________________

I am: ❑ Married ❑ In a Partnership ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

I live with: ❑ Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends ❑ Alone

Occupation: ______________________________ Hours of work per week: __________

Name of Spouse/Parent: ______________________________

Emergency Contact Person: ______________________ Phone Number: ______________

How did you hear about Hill Park Medical Center? ______________________________

____

____

Reason for today's visit: ______________________________

____

____

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices: ______________________________
signature

I have elected not to receive a copy of the Notice of Privacy Practices: ______________________________
signature

HILL PARK MEDICAL CENTER
PATIENT MEDICAL DATA

Name: ______________________________ Date: ____________

Please list all allergies and sensitivities. (drugs, foods, chemicals, environmental): ____________

Please list all current medications (include over-the-counter and prescription medications):

name	*dose*	*how often*

Supplement list (Please list all herbs, vitamins, nutritional supplements, with dosage if possible): ____________

Please list all medical diagnoses: ____________

Please list all surgeries (with year): ____________

Please list all hospitalizations (with year): ____________

Please list all therapies you use (acupuncture, massage, physical therapy etc.): ____________

HILL PARK MEDICAL CENTER
HEALTH HISTORY

Name: ______________________ Date: __________

Please list your health problems in order of importance to you

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

FAMILY HISTORY

	Mother	Father	Sisters	Brothers	Children
Age (if living)					
Health (Good, fair, poor)					
Age of Death (if deceased)					

Check all that apply:	Mother	Father	Sisters	Brothers	Children
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Mental Illness					
Asthma					
Eczema					
Hayfever					
Anemia					
Kidney Disease					
Tuberculosis					
Thyroid Disease					

HILL PARK MEDICAL CENTER
LIFESTYLE AND HABITS

Name: ______________________ Date: __________

Describe a typical meal:

Breakfast ______________________

____

Lunch ______________________

____

Dinner ______________________

____

Snacks ______________________

____

To Drink ______________________

____

Do you:	Yes	No	
Average 6-8 hours sleep?			What are your three favorite foods? ______
Have a supportive relationship?			______
Have a history of abuse?			______
Have a history of trauma?			What three foods do you dislike the most? ______
Enjoy your work?			______
Take Vacations?			______
Spend time outside?			______
Watch Television?			How many hours weekly?
Read Books?			How many hours weekly?
Computer games/browsing?			How many hours weekly?
Spiritual / religious practice?			Please describe:
Do you smoke?			How much?
Did you smoke in the past?			How many years? How many packs?
Do you eat three meals per day?			
Do you eat out often?			How many meals a week?
Do you drink coffee?			How many cups?
Do you drink tea?			How many cups?
Do you drink soft drinks?			How many a day?
Do you use sugar?			How much?
Use alcoholic beverages?			How often?

HILL PARK MEDICAL CENTER
REVIEW OF SYSTEMS

Name: ______________________________ Date: ____________

Y= a problem you have now **N= never had this problems** **P= had it in the past but not now**

Mental/Emotional	**Y**	**N**	**P**
Mood Swings			
Depression			
Anxiety/Nervousness			
High Stress Level			
Memory Problems			
Considered Suicide			
Poor Concentration			
Musculoskeletal	**Y**	**N**	**P**
Joint Pain			
Joint Stiffness			
Back Pain			
Neck Pain			
Weakness			
Broken Bones			
Arthritis			
Sciatica			
Muscle Spasm			
Endocrine	**Y**	**N**	**P**
Hypothyroidism			
Hypoglycema			
Excessive Thirst			
Fatigue			
Feel too hot			
Feel too cold			
Excessive hunger			
Seasonal Depression			
Immune	**Y**	**N**	**P**
Chronic Infections			
Slow Wound Healing			
Chronic Fatigue Syndrome			
Frequent Infections			

Neurologic	**Y**	**N**	**P**
Seizures			
Muscle Weakness			
Loss of Memory			
Dizziness			
Paralysis			
Numbness			
Tingling			
Skin	**Y**	**N**	**P**
Rashes			
Acne			
Boils			
Lumps			
Eczema			
Hives			
Hair Loss			
Night Sweats			
Head	**Y**	**N**	**P**
Headaches			
Migraines			
Head Injury			
Jaw/TMJ Pain			
Eyes	**Y**	**N**	**P**
Impaired Vision			
Spots in Vision			
Cataracts			
Glasses or Contacts			
Eye Pain			
Dryness			
Glaucoma			
Ears	**Y**	**N**	**P**
Impaired Hearing			
Earaches			

Ringing			
Dizziness			
Nose and Sinus	**Y**	**N**	**P**
Frequent Colds			
Stuffiness			
Sinus Pain			
Nose Bleeds			
Hayfever			
Mouth and Throat	**Y**	**N**	**P**
Sore Throats			
Teeth Grinding			
Gum Problems			
Dental Cavities			
Jaw Clicks			
Hoarseness			
Neck	**Y**	**N**	**P**
Lumps			
Goiter			
Swollen Glands			
Pain/Stiffness			
Respiratory	**Y**	**N**	**P**
Cough			
Spitting up Blood			
Asthma			
Pneumonia			
Pain on breathing			
Tuberculosis			
Difficulty Breathing			
Bronchitis			
Blood Vessels	**Y**	**N**	**P**
Easy Bleeding/Bruising			
Deep Leg Pain			
Varicose Veins			

HILL PARK MEDICAL CENTER
REVIEW OF SYSTEMS

Y= a problem you have now

N= never had this problems

P= had it in the past but not now

Name: ______________________ Date: __________

Blood Vessels (cont.)	**Y**	**N**	**P**
Anemia			
Cold Hands/Feet			
Thrombophlebitis			
Cardiovascular	**Y**	**N**	**P**
Heart Disease			
High Blood Pressure			
Low Blood Pressure			
Blood Clots			
Phlebitis			
Rheumatic Fever			
Swelling in Ankles			
Angina			
Heart Murmurs			
Fainting			
Irregular Heartbeat			
Chest Pain			
Gastrointestinal	**Y**	**N**	**P**
Nausea			
Vomiting			
Vomiting Blood			
Trouble Swallowing			
Blood in Stool			
Pain/Cramps/Bloating			
Belching or Gas			
Gall Bladder Disease			
Liver Disease			
Heartburn			
Change in Appetite			
Constipation			
Diarrhea			
Black Stools			
Ulcers			

Hemorrhoids			
Bowel Movements–how often?			
Urinary	**Y**	**N**	**P**
Pain on Urination			
Frequency			
Frequent Infections			
Inability to Hold Urine			
Frequency at Night			
Kidney Stones			
Male Reproductive	**Y**	**N**	**P**
Testicular pain			
Sexually Active			
Premature Ejaculation			
Impotence			
Prostate Disease			
Hernias			
Testicular Masses			
Sexually Transmitted Disease			
What kinds?			
Female Reproduction	**Y**	**N**	**P**
Age of First Period			
Date of Last Period			
Age of last Period (if menopausal)			
Length of Cycles			
Are they Regular?			
Bleeding Between Cycles			
Clotting/Heavy Bleeding			
Discharge			
How many days each period?			
Menopause Symptoms			
Painful Periods			
Endometriosis			
Ovarian Cysts			

Sexually Active			
Sexual Difficulties			
Birth Control			
What type?			
Sexually Transmitted Disease			
What kinds?			
Abnormal Pap			
Breast Lumps			
Breast Pain			
Nipple Discharge			
PMS			
What symptoms?			
Number Pregnancies			
Number Live Births			
Number Miscarriages			
Number Abortions			
General			
How much do you weigh?			
Are you happy with your weight? Y/N			
Childhood Illnesses (circle) Mumps, Measles, Diptheria, Chicken Pox, German Measles, Rheumatic Fever			
Immunizations (circle) Polio, Tetanus, Measles/Mumps/Rubella, Pertussis, Diptheria, Meningitis, Other			
X Rays and Special Studies *List scans and X-rays you have had. Include CAT scans, MRI scans, X-rays, other special studies and Heart Studies like EKGs.*			

HILL PARK MEDICAL CENTER
PAIN LOCATION CHART—Male

Name: ______________________________ Date: ______________

Use the body diagram below to indicate the location of any of the sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.

Symbol	Sensation
= = = = =	Numbness
o o o o o o	Pins and Needles
x x x x x	Burning Pain
/ / / / /	Stabbing Pain
/\ /\ /\ /\ /\	Aching Pain

right left left right