St. Pete Direct Primary Care

REGISTRATION FORM

Patient Registration Form Please Print Clearly			
All Fields Must Be Completed			
Date:	Social Security #:		
First Name:	MI:	Last:	Suffix:
Sex: M / F	Date of Birth:	Age:	
Marital Status (circle one): Single Married Divorced Widowed Legally Separated Other			
Race:	Country of Birth:	Primary Language:	

Patient's Permanent Address		Employment Status	
Address:		(Please Circle One) Employed □ Self-Employed □ Retired Disabled □ Unemployed □ Student	
City:		Employer Name:	
State:	Zip:	Address:	
Please Circle Preferred Method of Communication		City:	
Home Phone:		State:	Zip:
Work Phone:		Work Phone:	
E-mail Address:		Work E-mail:	

Who is your Primary Care Doctor:
Who can we thank for referring you today? (circle one) Referral Service □ Walk-in □ Friend □ Internet □ Social Media □ Other _____

Financial Info		
Financial Responsible Party or Guarantor Name:		DOB:
Address:	City:	
	State:	Zip:

Insurance Information	
Primary Carrier:	Secondary Carrier:
Subscriber:	Subscriber:
Subscriber DOB:	Subscriber DOB:
Subscriber ID #:	Subscriber ID #:

Emergency Contact Information	
Name:	Relationship to Patient:
Phone:	Work Phone:

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Who is the legal guardian for the patient? Please circle one: Self or Other	If Other, Name: Phone:

PATIENT PAST MEDICAL, FAMILY & SOCIAL HISTORY

Instructions: Complete the following information by placing a check mark (□) in the appropriate boxes or by printing the requested information. Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all pages. If you cannot remember specific details, please provide your best guess.

Today's Date: _____/_____/_____

Patient's Full Name (Last, First, M.I.): _____

Social Security #: ____ ____ ___- ____ ____-____ ____ ____ ____

Date of Birth: _____/_____/_____ Sex: □ Male □ Female Age: _____

Describe briefly your present symptoms: _____

PAST MEDICAL HISTORY:

Have you ever been hospitalized? □ No □ Yes
Have you had any serious injuries and/or broken bones? □ No □ Yes (specify) _____
Have you ever received a blood transfusion? □ No □ Yes □ when _____
Have you ever travelled or lived outside of the US or Canada? □ No □ Yes □ when and where?
How would you rate your health? □ Excellent □ Good □ Fair □ Poor

Have you received the following IMMUNIZATIONS? If yes, indicate the approximate year it was last given.

Pneumococcal (for pneumonia) □ Unknown □ No □ Yes □ Year _____
Hepatitis A □ Unknown □ No □ Yes □ Year _____
Hepatitis B □ Unknown □ No □ Yes □ Year _____
Tetanus/Diphtheria within last 10 years □ Unknown □ No □ Yes □ Year _____
Influenza (flu) □ Unknown □ No □ Yes □ Year _____ Measles □ Unknown □ No □ Yes □ Year _____
Mumps □ Unknown □ No □ Yes □ Year _____ Rubella □ Unknown □ No □ Yes □ Year _____
Polio □ Unknown □ No □ Yes □ Year _____

PERSONAL MEDICAL HISTORY: Have you ever had any of the following? (check □ all that apply)

Condition	No	Yes	Describe the issue (when appropriate)
Abnormal chest x-ray	□	□	
Anesthesia complications	□	□	
Anxiety, depression, or mental illness	□	□	
Blood problems (abnormal bleeding, anemia, high or low white count)	□	□	
Diabetes	□	□	
Growth removed from the colon or rectum (polyp or tumor)	□	□	
High blood pressure	□	□	
High cholesterol or triglycerides	□	□	
Sexually transmitted disease	□	□	
Condition	No	Yes	Describe the issue (when appropriate)
Stroke or TIA	□	□	
Treatment for alcohol/drug abuse	□	□	
Tuberculosis or positive tuberculin skin test	□	□	
Cosmetic or plastic surgery	□	□	

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (□) in the appropriate boxes. If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	No Problem	Medical Problem	Surgery	Year(s) of Surgery	Describe
Eyes (cataracts, glaucoma)	□	□	□		
Earns, nose, sinuses, or tonsils	□	□	□		
Thyroid or parathyroid glands	□	□	□		
Heart valves or abnormal heart rhythm	□	□	□		
Coronary (heart) arteries (angina)	□	□	□		
Arteries (aorta, arteries to head, arms, legs)	□	□	□		
Veins or blood clots in veins	□	□	□		

Lungs	☐	☐	☐		
Esophagus or stomach (ulcer)	☐	☐	☐		
Bowel (small & large intestine)	☐	☐	☐		
Appendix	☐	☐	☐		
Liver or gallbladder (including hepatitis)	☐	☐	☐		
Hernia	☐	☐	☐		
Kidneys or bladder	☐	☐	☐		
Bones, joints, or muscles	☐	☐	☐		
Back, neck, or spine	☐	☐	☐		
	No Problem	Medical Problem	Surgery	Year(s) of Surgery	Describe
Brain	☐	☐	☐		
Skin	☐	☐	☐		
Breasts	☐	☐	☐		
Females: uterus, tubes, ovaries	☐	☐	☐		
Males: prostate, penis, testes, vasectomy	☐	☐	☐		
Other: Describe	☐	☐	☐		

☐ Check box if you have no history of significant medical illnesses.

SURGICAL PROCEDURES: Please list any procedure/surgeries; include any abnormal finding, details, or complications.

MEDICATIONS: Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal remedies, and cold medications? □ No □ Yes □ If so, please list them below:

Medication	Dose (e.g., mg/pill)	How many times per day?

Are there other medications you have recently used? □ No □ Yes
Have you taken aspirin-containing products in the last two weeks? □ No □ Yes
Have you taken cortisone-type drugs within the last year? □ No □ Yes

ALLERGIES: Have you ever had hives, skin rash, breathing problems, or other allergic reactions to medications? □ No □ Yes □ List medications below:

Name of Medication	Describe Allergic Reaction

Are there medications, other than those you are allergic to, that you would prefer not to take due to unpleasant side effects? □ No □ Yes □ Please specify:

Have you ever had an allergic reaction to:

Iodine or X-ray contrast die □ No □ Yes	Bee or wasp stings □ No □ Yes
Latex or Rubber □ No □ Yes	Adhesive tape □ No □ Yes
List any food allergies: □ None	

SYSTEMS REVIEW: Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking (□) the box or each item.

GENERAL
□ Recent weight gain; how much____
□ Recent weight loss: how much____
□ Fatigue
□ Weakness
□ Fever
□ Night sweats

MUSCLE/JOINTS/BONES
□ Numbness
□ Joint pain
□ Muscle weakness
□ Joint swelling
Where?

EARS
□ Ringing in ears
□ Loss of hearing

EYES
□ Pain
□ Redness
□ Loss of vision
□ Double or blurred vision
□ Dryness

THROAT
□ Frequent sore throats
□ Hoarseness
□ Difficulty in swallowing
□ Pain in jaw

HEART AND LUNGS
□ Chest pain
□ Palpitations
□ Shortness of breath □
Fainting
□ Swollen legs or feet
□ Cough

NERVOUS SYSTEM
□ Headaches
□ Dizziness
□ Fainting or loss of consciousness
□ Numbness or tingling
□ Memory loss

STOMACH AND INTESTINES
□ Nausea
□ Heartburn
□ Stomach pain
□ Vomiting
□ Yellow jaundice
□ Increasing constipation
□ Persistent diarrhea
□ Blood in stools
□ Black stools

SKIN
□ Redness
□ Rash
□ Nodules/bumps
□ Hair loss
□ Color changes of hands or feet

BLOOD
□ Anemia
□ Clots

KIDNEY/URINE/BLADDER
□ Frequent or painful urination
□ Blood in urine

PSYCHIATRIC
□ Depression
□ Excessive worries
□ Difficulty falling asleep
□ Difficulty staying asleep
□ Difficulties with sexual arousal
□ Poor appetite
□ Food cravings
□ Frequent crying
□ Sensitivity
□ Thoughts of suicide / attempts
□ Stress
□ Irritability
□ Poor concentration
□ Racing thoughts
□ Hallucinations
□ Rapid speech
□ Guilty thoughts
□ Paranoia
□ Mood swings
□ Anxiety
□ Risky behavior

OTHER PROBLEMS:

BEHAVIORAL ISSUES: Check (□) all that apply.

Tobacco Use:
Smoke or smoked: cigarettes, pipe, cigars? □ No □ Yes
Exposure to second hand smoke?
□ No □ Yes
Current smoker
Packs/day: _____ # of years: _____
Are you ready to quit? □ No □ Yes
Former smoker
How many years did you smoke? _____
Quit date: _____
Approximately how many packs/day did you smoke?
_____
Other tobacco? Snuff or Chew (circle)
Currently use? Quit date: _____

Sexual Activity:
Are you sexually involved?
□ No □ Yes
Sexual partner(s) is/are/have been/may be in the future:
□ No □ Yes
Birth control method or STI prevention (check all that apply):
□ None needed □ Diaphragm
□ Condom □ Vasectomy
□ Pill □ Tubal ligation
□ IUD □ Ring
□ Patch □ Other method (Specify)

Alcohol Use:
Do you drink alcohol? □ No □ Yes
# of drinks/week: _____
How many times in a year do you have 3 or more drinks (for women), 4 or more (for men)? _____

Other (ALD):
Military Service? □ No □ Yes
Blood Transfusion? □ No □ Yes
Exposure to toxic chemicals? □ No □ Yes

Drug Use:
Have you ever used recreational drugs? □ No □ Yes
If yes, which ones? _____
Quit which ones? _____
Any used currently? □ No □ Yes

FAMILY HISTORY:
Adopted? □ No □ Yes. If adopted and you do not know your family history, skip this section and continue to Health Issues.

Complete the following information about your blood relatives. Exclude adoptive siblings and children.

Father	□ Alive (Age ___)	□ Deceased (Age ____)	□ Unknown	Cause of Death:	□ Unknown
Mother	□ Alive (Age ___)	□ Deceased (Age ____)	□ Unknown	Cause of Death:	□ Unknown

	Number Alive	Approx. Age(s)	Number Deceased	Appx. Age(s) at Death	
Brothers	_____	_____	_____	_____	□ Unknown
Sisters	_____	_____	_____	_____	□ Unknown
Sons	_____	_____	_____	_____	□ Unknown
Daughters	_____	_____	_____	_____	□ Unknown

(Family History Continues on Next Page)

Place a check mark (□) in the appropriate boxes to identify all illnesses/conditions which you know have occurred in your blood relatives. Check "NONE" if you are not aware of any relative having the illness/condition. Describe the illness/condition.

Illness/Condition	Family Members								Describe
	Grandparents	Father	Mother	Brothers	Sisters	Sons	Daughters	None	
Cancer (describe the type of cancer for each person)									
Heart Disease									
Stroke/TIA									
High Blood Pressure									
High Cholesterol or Triglycerides									
Liver Disease									
Alcohol or Drug Abuse									
Anxiety, Depressing or Psychiatric Illness									
Tuberculosis									
Anesthesia Complications									
Genetic Disorder									
Other (describe)									

Other Information about your family you want us to know: _____

SELF-CARE/HOME ENVIRONMENT:

Do you have difficultly performing these activities by YOURSELF?

□ Eating □ Bathing □ Dressing □ Walking □ Using Toilet □ Housekeeping

Do you have any special dietary needs? □ No □ Yes

If yes, specify: □ vegetarian □ vegan □ gluten free □ other _____

Do you exercise regularly? □ No □ Yes

If Yes, what kind of exercise? _____ How long? _____ minutes How often? _____

In the past two weeks, have you been feeling down, depressed, or hopeless? □ No □ Yes Do you have little interest or pleasure in doing things? □ No □ Yes

SOCIAL HISTORY:

Name you prefer we use when contacting you (nickname, first, or last with Mr. Mrs. Ms., etc.): _____

What is your current living arrangement? □ House □ Apartment □ Nursing Home □ Other

Who lives at home with you? □ No one □ Spouse/Partner □ Children □ Pets (what kind) □ Other (roommates, extended family, etc.): _____

Please list your interests, hobbies, involvement, volunteer work, and/or travel outside of the US (past 6 months):

SOCIOECONOMIC:

Occupation (or prior occupation): _____ Employer: _____

If you are not currently working, you are: □ retired □ unemployed □ leave of absence □ disabled □ other

Education: □ high school/GED □ trade school □ college □ graduate school □ other _____

Marital status: □ single □ partner □ married □ divorced □ other _____

Spouse/partner's name: _____

MEDICAL FORMS: Please check any of the following forms you have completed

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN'S HEALTH HISTORY

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? □ No □ Yes □ At what age?

Do you have regular periods? □ No □ Yes

Do you have concerns about your periods or menopause you'd like to discuss: □ No □ Yes

If you are having periods, how often do they occur? Every _____ days. How long do they last? ____

Test	When/Where	Abnormal?	If yes, Describe
Mammogram		□ No □ Yes	
Pap Smear		□ No □ Yes	
Bone Density Test		□ No □ Yes	