Patient Registration

Last Name _____ First _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

Sex: ☐ Male ☐ Female Birthdate _____ Age _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Birthdate _____

Social Security # _____ Employer _____ Phone # _____

Work Address _____ City _____ State _____ Zip _____

In case of emergency, please notify _____ Phone # _____

How did you learn of our practice? _____

Insurance Information

Primary Insurance _____

Subscriber's Last Name _____

Subscriber's First Name _____

Social Security # _____ Group # _____

Employer _____

Secondary Insurance _____

Subscriber's Last Name _____

Subscriber's First Name _____

Social Security # _____ Group # _____

Employer _____

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or major medical benefit to which I am entitled to and I hereby authorize you to make direct payment to **David A. Palmore, M.D., Inc.** of any benefits payable to me under the conditions of my policy. I understand I am financially responsible for charges not covered by this assignment.

Signature _____ Date _____

DAP

DAVID A. PALMORE M.D.

Internal Medicine for over 30 years.

THE OFFICE OF

DAVID A PALMORE M.D. INC

1. Reason for appointment?

2. Date of onset?

3. Have you been treated by any other physician for this condition?

4. What treatment was given

5. Are you currently on any medications?

6. Are you on ant narcotic pain medications?

7. Are you planning to ask for pain medications?

8. Are you on any medications for sleep or anxiety?

9. Are you planning to ask for any for sleep or anxiety?

10. Reason for leaving previous physician?

Please be aware that the physician does not feel comfortable prescribing controlled substances of any kind. Please submit questionnaire and packet as soon as possible so that the physician may review and we can schedule an appointment for you.

Thank you

Patient signature_____

PATIENT MEDICATION RECORD

PATIENT NAME:	D.O.B:
ALLERGIES:	
PHARMACY:	

MEDICATIONS

DATE:	MEDICATION	DOSE/	ROUTE	FREQ	DC'D	SAMPLE

Patient Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

List medications you are currently taking

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

Pharmacy Name_____ Phone_____

Health History

Family History (Fill in health information about your immediate family)

	Age	State of Health	Age at Death	Cause of Death
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				

Check (✓) if your blood relatives had any of the following:

☑	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer (type)	
	Chemical dependency	
	Diabetes	
	Heart disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other:	

Hospitalizations & Surgeries

Year	Hospital	Reason for Hospitalization and Outcome

Date	Serious Illness or Injury	Outcome

Have you ever had a blood transfusion? **Yes** or **No** if yes, please give approximate date(s): _____, _____, _____

Health Habits

(Circle which substances you use and describe how much you use)

Alcohol: _____

Caffeine: _____

Drugs: _____

Tobacco: _____

Other: _____

Occupational

(Circle if your work exposes you to any of the following)

Heavy Lifting

Hazardous Substances

Stress

Other: _____

_____

Pregnancies

Year of Birth | Sex | Complications, if any

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date