QUALITY MEDICAL CENTER of CROSSVILLE, PC

PATIENT REGISTRATION (Please Print)

TODAYS DATE:_____ Birthdate:_____

Legal Name: **Marital status (circle one)**

PATIENT:_____Single/Married/Seperated/Widowed
LAST FIRST MIDDLE

STREET ADDRESS:_____CITY STATE, ZIP_____

Home PHONE #_____CELL#_____SOCIAL SECURITY#_____

EMPLOYER_____// Employers Phone#_____

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SPOUSE /GUARDIAN_____RELATION TO PATIENT_____

DOB:_____ EMPLOYER:_____ WORK PHONE#_____

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***EMERGENCY CONTACT / /*NEAREST RELATIVE// *NOT LIVING* WITH PATIENT//_____**

RELATION TO PATIENT:_____PHONE:_____

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REGULAR PHYSICIAN_____

PREFERRED PHARMACY_____

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Insurance Name_____Subscriber_____

Secondary Insurance_____Subscriber_____

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I hereby certify that the information given by me is correct.

PATIENT/GUARDIAN(signature)**_____RELATIONSHIP TO PATIENT_____**

TURN OVER & COMPLETE BACK PAGE

HEALTH HISTORY

PATIENT NAME:_____WEIGHT_____ HEIGHT_____

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MEDICAL HISTORY/Have you had (or do you have) any of the following problems (**please circle all that apply and put year diagnosed)** **Review of systems:**

High Blood Pressure	Cancer	Asthma	Lung Disease
Abnormal Pap Smear	Heart Disease	Arthritis	Urinary Tract Infection
Heart Attack	Tuberculosis	Seizure Disorder	Liver Disease/Hepatitis
Pancreas Disorder	Stroke	Blood Transfusion	Diabetes
Anemia	STDs	Thyroid Disease	Kidney Disease
HIV/AIDS	Eye Disorders	Other:_____	

PATIENT SOCIAL HISTORY:

Use of Tobacco: Never Rarely Daily____How Long____years:_____Previously, but quit_____yrs

Use of Caffeine: Never Rarely Daily Coffee/Tea:_____Cups Daily_____;

Use of Alcohol : Never Rarely Daily Previously, but quit_____yrs

MEDICATIONS:(Please list or show us your own printed record) /// **TAKE NO MEDICATIONS_____**

Medication Strength How many times per day?

_____

_____

_____

_____

_____

_____

_____

_____

Allergies or intolerance to medications_____

_____

List any *injuries/surgeries* the patient has had and year:_____

_____

_____

Female: Total pregnancies:____ #Live births_____#Miscarriages_____Last menstrual period_____Hysterectomy/month year_____

Last PAP Smear/month & year_____

Last Mammogram/month & year_____Have you had a colonoscopy_____Date:_____ Are you Pregnant_____

Male: Last PSA_____Prostate Exam_____ Have you had a colonoscopy_____Date_____

Kids Only*(less than 18 years*): Immunizations Up To Date:_____Yes_____No

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List FAMILY Medical History//*(Other Than Yourself)*

Parents/Brothers/Sisters/Grandparents/Aunts/Uncles_____

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_____

_____

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To the best of my knowledge, all of the above answers are correct:

Patient/Guardian Signature:_____Date_____