Alejandro Posada, MD

PATIENT REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name | First name | | | | | Middle initial | | | | |
| SEX Male □ Female □ | Date of birth | | | | | Marital Status | | | | |
| Street address | | | City | | | | | State | Zip | |
| Home phone number | | Mobile number | | | | Work number | | | | |
| Email address | | | |  | | | | | | |
| How did you hear about her office  Internet □ Previous Patient □ Insurance Company □ Friend/Relative □ Physician □ | | | | | | | | | | |
| Race  American Indian □ Asian/Oriental □ Black/African-American □ White □ Other □ | | | | | | | | | | |
| Primary Care Physician | | | | | | | | | | |
| Last name | | | | | First name | | | | | |
| PCP Phone | | | PCP address | | | | | | | |
| Pharmacy Information | | | | | | | | | | |
| Pharmacy name | | | Pharmacy phone number | | | | | | | |
| Pharmacy address | | | | | | | | | | |
| Employer information | | | | | | | | | | |
| Occupation | | | Employer name | | | | | | | |
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|  | | | | | | | | | | |
| Reason for your visit | | | | | | | | | | |
| Where is the problem? (Shoulder, knee, etc.) Space Which side (right, left)? | | | | | | | | | | |
| When did you first experience problems? (Please give approximate date) | | | | | | | | | | |
| If you had an injury, please describe (include date of injury) | | | | | | | | | | |
| Describe your problem | | | | | | | | | | |
|  | | | | | | | YES | | | NO |
| Is this case involved in litigation or will it be involved in litigation? | | | | | | |  | | |  |
| Is this a workers compensation injury? | | | | | | |  | | |  |
| Have you had x-rays? | | | | | | |  | | |  |
| Have you had an MRI? | | | | | | |  | | |  |

PAST MEDICAL HISTORY

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Past surgical history | | | | | | | | | | | |
| Surgery | | Reason | | | | | | | Year | | |
| 1. | |  | | | | | | |  | | |
| 2. | |  | | | | | | |  | | |
| 3. | |  | | | | | | |  | | |
| 4. | |  | | | | | | |  | | |
| ALLERGIES/sensitivities to medication/reaction | | | | | | | | | | | |
| 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| 3. | | | | | | | | | | | |
| 4. | | | | | | | | | | | |
| 5. | | | | | | | | | | | |
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| Past medical history | | | | | | | | | | | |
|  | Yes | No |  | | | Yes | No |  | | Yes | No |
| Allergies |  |  | Diabetes | | |  |  | Lung disease | |  |  |
| Anemia |  |  | Diabetic complications | | |  |  | Mental disorder | |  |  |
| Anxiety |  |  | Endocrine disease | | |  |  | Movement disorder | |  |  |
| Arthritis asthma |  |  | Eye problems | | |  |  | Nerve disease | |  |  |
| Autoimmune disease |  |  | Gastritis/ulcer | | |  |  | Osteoporosis/osteopenia | |  |  |
| Back pain |  |  | GERD/acid reflux | | |  |  | Obesity/overweight | |  |  |
| Blood disorder |  |  | Headaches/migraines | | |  |  | Pneumonia | |  |  |
| Bowel disease |  |  | Hearing loss | | |  |  | Prostate cancer | |  |  |
| CAD |  |  | Heart rhythm disorder | | |  |  | Spine disease | |  |  |
| CHF |  |  | Heart disease | | |  |  | Stroke/TIA | |  |  |
| COPD |  |  | Hypertension | | |  |  | Thyroid disease | |  |  |
| Cancer |  |  | Hyperlipidemia | | |  |  | Tuberculosis/positive PPD | |  |  |
| Dementia |  |  | Kidney disease/stones | | |  |  | Urinary problems | |  |  |
| Developmental |  |  | Liver disease | | |  |  | Viral disease | |  |  |
| Depression |  |  |  | | |  |  |  | |  |  |
| Other | | | | | | | | | | | |
| Family Health History | | | | | | | | | | | |
| Relationship | | | | Age of onset | | | | | Significant health problems | | |
| 1. | | | |  | | | | |  | | |
| 2. | | | |  | | | | |  | | |
| 3. | | | |  | | | | |  | | |
| 4. | | | |  | | | | |  | | |
| MEDICATIONS | | | | | | | | | | | |
| Name of medication | | | | | Dose | | | | Frequency taken | | |
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| SOCIAL HISTORY | | | | | | | | | | | |
| Do you smoke tobacco, if so how much? | | | | | | | | | | | |
| Do you drink caffeine, if so how much? | | | | | | | | | | | |
| Do you currently use recreational or street drugs? If so which one? | | | | | | | | | | | |
| Do you have a history of drug abuse? | | | | | | | | | | | |

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_