Brijcare Family Medicine

Family Medicine Registration Form

Please print and use black ink.

Patient's Information

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Last Name: ______________________________

Address Line 1: ______________________________

Address Line 2: ______________________________

City: ______________________________

State: ____________________ Zip Code: _______

Race: ____________Ethnicity: ______________

Preferred Pharmacy: ______________________

Occupation/Employer: ______________________

Previous Doctor: __________________________

Date of Last Appointment: __________________

Do you consent to communication via text? ☐ Yes ☐ No

First Name: ______________ Middle Initial: _____

Date of Birth: _____________ Gender: M or F

Home Phone: (______) ______________________

Work Phone: (______) Cell Phone: (______)

Social Security #: __________________________

Driver License State ____# __________________

Email Address: ____________________________

Date of Last Wellness Appointment:____________

Reason for Leaving: _________________________

Complete list of ALL medications taken in past year:

____

____

____

Emergency Contact Information (A local person)

Last Name: ______________________________ First Name: ______________________________

Relationship: ______________________________

Home Phone: (______) ______________________

Cell Phone: (______) ______________________

Work Phone: (_____) ________________

HIPAA Disclosure (People other than yourself)

Name: ______________________________ Name: ______________________________

Relationship: ______________________________ Relationship: ______________________________

Phone: (_______) ______________________ Phone: (______) ______________________

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Subscriber Information Please provide all applicable insurances. Not providing all the insurance information will result in a delay in making your first appointment.

Last Name: ___________________________________

First Name: ________________Middle Initial: _____

Address Line 1: ________________________________

Date of Birth: ______________ Gender: M or F

Address Line 2: ________________________________

Home Phone: (______) ______________________

City: _____________________________________

Work Phone: (______) ______________________

State: _______________ Zip Code: _______________

Cell Phone: (______) ______________________

Social Security #: _____________________________

Email Address:_________________________________

Primary Insurance Company: ______________________

Subscriber ID Number: _________________________

Group Number on Insurance Card: _________________

Phone # on Back of Card: _____________________

Secondary Insurance Company: ___________________

Subscriber ID Number: _________________________

Group Number on Insurance Card _________________

Phone # on Back of Card: ______________________

How did you hear about us? Check One

Friend	TV	Advertisement	Google/Internet	Yellow Pages

Newspaper Ad	PR Manager	Facebook	OBGYN	Other: please explain

HEALTH QUESTIONNAIRE

Please indicate each of your chronic medical problems by marking the appropriate box below:

○ High Blood Pressure	○ Asthma	Please list any other medical problems:
○ Heart Disease	○ Emphysema/Lung Disease	
○ Diabetes	○ Kidney Problems	
○ Stroke	○ Anemia	
○ Cancer	○ High Cholesterol	
○Thyroid	○ Glaucoma	

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Please list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications, vitamins, and herbal supplements.

Are you allergic to any medications? ○ Yes ○ No If yes, please list them and the reaction they cause.

Do you require assistance for hearing impaired? ○ Yes ○ No

Social History

Tobacco use: ○ No ○ Yes ______________ a day Number of years used: Year Quit: ______________
Alcohol use: ○ No ○ Yes ____________ drinks per week Street Drugs: ○ No ○ Yes Specify:
Caffeine: ○ No ○ Yes ______________ cups a day Low fat diet: ○ No ○ Yes Water: cups a day
Exercise: ○ Yes ○ No Type: Times a week: minutes/sessions
# of Children: __________ Do you have a living will? ○ Yes ○ No If yes, have you given us a copy? ○ Yes ○ No Marital Status: Occupation:

Family History

If any blood relative has suffered from the following conditions, check the box and indicate which relative.

○ Heart Disease	○ Stroke	○ Asthma	○ Glaucoma
○ Diabetes	○ High Blood Pressure	○ Emphysema/Lung Disease	○ Mental Health
○ Thyroid	○ High Cholesterol	○ Cancer	○ Substance Abuse

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Please list any surgeries/hospitalizations (including the year):

Are you under the care of any other doctor for any medical problems? ______________________________

If so, whom and for what medical problem? ______________________________

Year of last: Tetanus Shot ____________ Flu Shot____________ Pneumonia Vaccine___________ MMR _________

Women only: Date of first day of last menstrual period: ______________ Contraceptive Type ________________

Number of: Pregnancies Live Births

Miscarriages Abortions

Date of last: PAP ____________ Abnormal (?)___________ Mammogram __________ Abnormal (?)___________

Flushing/Menopausal Symptoms o Yes o No

Have you been a victim of abuse? o Yes o No

Men only: Date of last: Prostate Exam _______________ Last PSA (Prostate Blood Test) ____________________

Procedures (list year):

Sigmoidoscopy	Colonoscopy	Stress Test
EKG	Cholesterol (normal Y/N)	Sugar (normal Y/N)

Please place a checkmark next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.

GENERAL	o Fever	o Night Sweats	o Unexplained Weight Loss or Gain		o Fatigue
SKIN	o Rashes	o Cancers	o Change in Hair, Skin or Nails		
EYES	o Glasses	o Contact Lenses	o Pain	o Changing Vision	o Discharge
EAR NOSE THROAT	o Ear Pain o Sore Throat	o Change in Hearing o Change in Voice	o Persistent Runny Nose o Sinus Trouble		
HEART	o Chest Pain	o Swelling in Ankles	o Palpitations	o Heart Murmur	
LUNGS	o Cough	o Shortness of Breath	o Wheezing		
GASTRO-INTESTINAL	o Nausea D o Ulcers	o Blood in Stool D o Heartburn	o Change in Bowel Movements		
GENITO-URINARY	o Blood in Urine **Women:** **Men:**	o Painful or Frequent Uri nation o (STD) o Vaginal Discharge o Testicular Pain o Penile Discharge	o Incontinence o Change in Menstrual Cycle or Sexual Function o Decreased Urinary Stream o Change in Sexual Function		
ORTHOPEDIC	o Painful Joints	o Muscle Weakness			

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NEURO/PSYCH	o Seizures	o Tremor	o Paralysis	o Frequent Headaches
	o Depression	o Anxiety		
ALLERGY	o Hives	o Hay Fever		
CIRCULATION	o Leg Swelling	o Blood Clots		

Patient Signature **Date**

____

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Witness Signature **Date**