AMB HEALTHTIPS & HOUSECALLS, INC

Medical Registration and Information

Name (Last/First):_____

Today's Date:_____

Date of Birth: _____

Address:

_____

City:_____State:_____Zip: _____

Phone:_____Home () Cell () Work ()

Email Address:

_____

Married: () Single: ()

Emergency Contact Name:

_____

Emergency Contact Phone:

_____

Relationship to you:

_____

Pharmacy Name & Phone:

_____

What is the reason for your visit?

_____

How did you hear about us?

_____

Health History

SYMPTOMS Check symptoms you currently have

GENERAL
- □ Major weight gain
- □ Major weight loss
- □ Fatigue
- □ Changes in sleep pattern
- □ Fever

EYE, EAR, NOSE, THROAT
- □ Sore Throat
- □ Mouth Sores
- □ Visual changes
- □ Double vision
- □ Ringing in the ears
- □ Hearing loss
- □ Ear pain
- □ Sinus congestion or pain
- □ Nosebleeds
- □ Hoarseness
- □ Difficulty swallowing

DERMATOLOGICAL
- □ Rash
- □ Warts
- □ Itching

BREASTS
- □ Pain
- □ Lumps
- □ Discharge

RESPIRATORY
- □ Wheezing
- □ Coughing
- □ Shortness of breath
- □ Coughing up blood

CARDIOVASCULAR
- □ Chest pain
- □ Palpitations
- □ Murmur
- □ Rapid Heartbeat
- □ Swollen Feet
- □ Swollen Hands

GASTROINTESTINAL
- □ Pain
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Changes in appetite
- □ Constipation
- □ Rectal bleeding

MUSCLE/JOINT/BONE
- □ Muscle pain
- □ Joint pain
- □ Decreased range of motion
- □ Weakness

NEUROLOGICAL
- □ Frequent headaches
- □ Dizziness
- □ Loss of conciseness
- □ Seizures
- □ Numbness/Tingling

ENDOCRINE
- □ Intolerance to heat
- □ Intolerance to cold
- □ Excessive hunger
- □ Excessive thirst

PSYCHIATRIC
- □ Anxiety
- □ Depression
- □ Insomnia
- □ Irritable
- □ Suicidal thoughts

GENITOURINARY
- □ Burning Urination
- □ Frequent Urination
- □ Blood in Urine

QUESTIONS

Are you pregnant?
_____ Yes_____No

Last Menstrual Period

Are you planning to become pregnant?
_____ Yes_____No

Do you Smoke?_____
_____ Per Day
_____ Per Week
_____ Per Month

Do you drink Alcohol?_____
_____ Per Day
_____ Per Week
_____ Per Month

Primary care physician

_____

Personal History

Check conditions you have or have had in the past

□ AIDS □ Alcoholism □ Anemia □ Anorexia □ Appendicitis □ Arthritis □ Asthma □ Bleeding Disorders □ Breast Lump □ Bronchitis □ Bulimia	□ Cancer □ Cataracts □ Chemical dependency □ Diabetes □ Emphysema □ Epilepsy □ Glaucoma □ Goiter □ Heart Disease □ Hepatitis □ High Cholesterol	□ HIV Positive □ Kidney Disease □ Liver Disease □ Migraine Headaches □ Miscarriage □ Mononucleosis □ Multiple Sclerosis □ Pacemaker □ Pneumonia □ Psychiatric Care □ Stroke	□ Suicide Attempt □ Thyroid Problems □ Tuberculosis □ Ulcers □ Sexually transmitted Disease Type_____ □ Other (please list) _____

Surgery History

Surgery	Year	Reason	Hospital

Family History

Check conditions that your immediate family (Grandparents, Parents, or Siblings) may have or have had

□ Diabetes _____ □ Heart Disease _____ □ Cancer*	□ Mental Illness _____ □ Stroke _____ □Type of Cancer*	□ Bleeding tendency _____ □ Kidney Disease _____ □ Type of Cancer Cont'	□ High blood Pressure _____ □ Other _____ □ Other
□ Cancer*	□Type of Cancer*	□ Type of Cancer Cont'	

MEDICATIONS: List all medications you take (***Including over the counter medications & herbs and medications taken as needed***)

Medication	Strength	How often	Reason	Prescribing Physician

ALLERGIES: List all allergies (**medications or substances**)

Allergy	Reaction