

New Patient Pre-Registration Form

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Email Address: _____ Phone: _____

Sex: Male Female Other

Current/ last Primary Care Physician: _____

Please Circle: **Sarah Harris FNP-C** **Tausha Rhoades AGACNP-C** **Madison Odom PA-C**

Current Specialists / other Doctors: _____

Primary Insurance: _____ Secondary Insurance: _____

Tertiary Insurance: _____

CURRENT MEDICATIONS: (All prescribed medications):

NAME OF MED	DOSE	FREQUENCY

MEDICAL HISTORY:

Please select all current and past medical problems you've been diagnosed with:

- | | |
|--|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Autoimmune Disorder – Type: _____ |
| <input type="checkbox"/> Diabetes-Last A1C: _____ Date _____ | <input type="checkbox"/> Chronic Pain – Body Part(s): _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Abnormal Pap Smear / HPV |
| <input type="checkbox"/> Thyroid Disorder: LOW HIGH | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Anemia – Type: _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizure Disorder / Epilepsy | <input type="checkbox"/> COPD / Emphysema |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> CVA (Stroke)/ TIA (Mini-Stroke) | <input type="checkbox"/> Depression/ Anxiety |
| <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Other Mental Health Issue - _____ |
| <input type="checkbox"/> Liver Disease – Type: _____ | <input type="checkbox"/> Substance Abuse - _____ |
| <input type="checkbox"/> Kidney Disease – Type: _____ | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer – Type: _____ |
| <input type="checkbox"/> Heart Disease – Type: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GERD (Chronic Heartburn) | |

Other Diagnosed Medical History:
