AFC Health

Action Family Care New Patient Registration

Please fill in the form below

Name

First Name Last Name

Date

Month Day Year

E-mail

example@example.com

Gender

Marital Status

Previous or Referring Doctor

Date of Last Physical Exam

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Weight (pounds)

Height (inches)

Contact Number:

Area Code   Phone Number

Address:

Street Address

Street Address Line 2

City   State / Province

Postal / Zip Code

In case of emergency...

Emergency Contact:

First Name   Last Name

Relationship

Preferred Pharmacy (Please include the address and phone number)

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About your Visit

What brings you in today?

When did the symptoms begin?

Pain level (0-10)

Nature of Injury (please explain)

Previous treatments

Medical History

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Medical Conditions

Childhood Illness

- Measles
- Mumps
- Rubella
- Chickenpox
- Rheumatic Fever
- Polio

Past Surgeries (please include year)

Past Hospitalizations (Please include year)

Type a question

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Allergies (please include reaction):

Family History

Taking any medications, currently?

Yes

No

Please list medications

Social History

Exercise Level (weekly)

None/sedentary

Low (climb stair, walk 3 blocks, golf)

Moderate (work or recreation less than 4 x week, 30 min)

High (work or recreation 4 x week, 30 min)

Please describe activity and number of hours/week

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Are you dieting?

- Yes
- No

If yes, are you on a prescribed medical diet?

meals on an average day?

Salt Intake

- Low
- Med
- Hi

Fat Intake

- Low
- Med
- Hi

Caffeine

- None
- Coffee
- Tea
- Cola

cups/cans daily

Do you smoke?

- Yes
- Occasionally
- No

If yes, packs/day?

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If you have quit, how long has it been since you last smoked, or used tobacco?

Alcohol use?

Yes
No

If yes, what kind of alcohol?

If yes, how many drinks/week?

Drug Use?

Yes
No

If yes, choose from following

CBD/THC
Methamphetamines
Cocaine
Heroin
Other

Other (please explain)

If yes, have you ever given yourself street drugs with a needle?

Are you sexually active?

Yes
No

If yes, are you trying to get pregnant?

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If not, provide method of contraception

Discomfort with intercourse?

Yes

No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?

Yes

No

Do you live alone?

Yes

No

Do you have frequent falls?

Yes

No

Do you have vision or hearing loss?

Yes

No

Mental Health

Do you feel depressed?

Yes

No

Do you panic when stressed?

Yes

No

Do you have problems with eating or your appetite?

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Yes
No

Do you cry frequently?

Yes
No

Have you ever attempted suicide?

Yes
No

Have you ever seriously thought about hurting yourself?

Yes
No

Do you have trouble sleeping?

Yes
No

Have you ever been to a counselor?

Yes
No

Women Only

Age of Onset of Menstruation:

Date of Last Menstruation:

How often do you get you period?

Do you have heavy periods, spotting, pain, or discharge?

Ye

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No

Number of Pregnancies

Number of Live Births

Are you pregnant or breastfeeding?

Yes

No

Have you had a D&C, hysterectomy, or cesarean?

Yes

No

Any urinary tract infections, bladder infections, or kidney infections in the last year?

Yes

No

Any blood in your urine?

Yes

No

Do you have problems controlling urination?

Yes

No

Any hot flashes or sweating at night?

Yes

No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?

Yes

No

Experienced any recent breast tenderness, lumps, or nipple discharge?

Ye

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No

Date of last pap exam?

Men Only

Do you usually get up to urinate during the night?

Yes
No

If yes, # times

Do you feel pain or burning with urination?

Yes
No

Any blood in your urine?

Yes
No

Do you feel burning discharge from penis?

Yes
No

Has the force of your urination decreased?

Yes
No

Have you had any kidney, bladder, or prostate infections within the last 12 months?

Yes
No

Do you have any problems emptying your bladder completely?

Yes

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Any difficulty with erection or ejaculation?

Yes

No

Date of last prostate and rectal exam?

Yes

No

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