CARDIOVASCULAR HEALTH ASSOCIATES **REGISTRATION AND HISTORY RECORD**

REGISTRATION DATA

1. Your name _____ □Male Sex □Female Date of birth____ mo / day / yr____ Marital Status _____

Address_____

STREET CITY STATE ZIP

Home phone ( )_____ Cell phone ( )_____ Race _____

2. Email Address: _____

3. Social Security No. _____ Employed by _____ Work phone ( )_____

4. Person to contact in an emergency _____ Relationship to you _____

Their work phone ( )_____ Their home phone ( ) _____

5-A. Primary Insurance _____ Policy # _____

Subscriber's Name _____ DOB _____

Subscriber's Social Security # _____—_____—_____

5-B. Secondary Insurance _____ Policy # _____

Subscriber's Name _____ DOB _____

Subscriber's Social Security # _____—_____—_____

6. Pharmacy Name _____ Address: _____

Pharmacy Phone _____

7. I hereby authorize Dr. _____ to furnish information to insurance carrier/ carriers concerning my diagnosis and treatments.

Date:_____ Signature: _____

8. I was referred by: _____

MEDICINES YOU ARE TAKING List medicines, birth control pills, or vitamins you take with or without a prescription:

_____ _____

_____ _____

_____ _____

_____ _____

DRUG and/or **OTHER ALLERGIES** List those to which you are allergic:

_____

_____

_____

_____

HOSPITALIZATIONS List serious illnesses and injuries or operations and approximate year. EXCLUDE NORMAL PREGNANCIES.

Year	Serious illness, injury or operation	Name of hospital	City and State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATIONS Check those that you have had. Note most recent year received

□Pneumonia _____ □Tetanus _____

□Polio _____ □Rubella _____

□Flu _____ _____ _____

□Others_____ _____

_____ _____

Do you have or have you been tested for sleep apnea? _____

Do you have a CPAP machine? _____

Do you use CPAP machine? _____

REGISTRATION AND HISTORY RECORD

YOUR FAMILY'S HEALTH

	First Name	Year of birth	Health is: Good	Health is: Poor	Died at	Age	Cause of death
Father			☐	☐	☐		
Mother			☐	☐	☐		
Brothers and Sisters			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
Spouse			☐	☐	☐		
Children			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
							Relationship to you
Others			☐	☐	☐		
Living in Household			☐	☐	☐		
			☐	☐	☐		

YOUR WORK/EXPOSURE HISTORY

Are you working now? ☐ Yes ☐ No, I'm out of work

☐ No, I'm retired ☐ I've never been employed

Starting with your most recent job, what type of work have you done?

	Type of work	From	To
1.		19_____	19_____
2.		19_____	19_____
3.		19_____	19_____

Check ☑ the items below that you have been exposed to in your work.

☐ Fumes and dust ☐ Coal, asbestos ☐ Salicylates, halothanes

☐ Lead, mercury, metal salts ☐ Solvents, degreasers ☐

☐ Smoker ☐ Current ☐ Former How long _____

HEALTH CARE PROVIDERS

Who else have you seen for your health care in the past five years?

Year	Name of doctor or other provider	Location City, State	Primary Problems Cared For

ILLNESSES Check ☑where you or members of your family have had the following illnesses or problems:

You	Your family	
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Cancer, tumor
☐	☐	Diabetes
☐	☐	Drug Abuse
☐	☐	Depression
☐	☐	Eczema, hives, rashes
☐	☐	Epilepsy
☐		Eye problems
☐	☐	Glaucoma
☐	☐	Heart disease
☐	☐	High blood pressure
☐	☐	Kidney/bladder problems
☐	☐	Liver disease, hepatitis, yellow jaundice
☐	☐	Lung disease, tuberculosis
☐		Mumps, measles, chicken pox
☐	☐	Nervous breakdown/ mental illness
☐	☐	Phlebitis
☐	☐	Rheumatic fever
☐		Rubella, German measles
☐	☐	Stroke
☐	☐	Suicide attempt
☐	☐	Thyroid disease
☐	☐	Ulcer in stomach/ duodenum
☐	☐	Uncontrolled bleeding
☐	☐	Venereal disease
		Other illnesses:
☐	☐	_____
☐	☐	_____

PREGNANCY HISTORY

Enter the number of:

Times pregnant..... _____

Premature births..... _____

Miscarriages..... _____

Abortions..... _____

Live births..... _____

Living children..... _____

Updated on ___/___/___/___

by