Gilbert Medical Group- Familydoctortoday.com
Registration Form

Email Address: _____

Today's date:						
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: Single / Married / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑Transgender ❑ M ❑ F	
Street address:		Social Security Number: - -			Cell phone number: ( ) -	
P.O. box:	City:		State:		ZIP Code:	
Occupation:	Employer:				Home phone number:	
Race:	Ethnicity: ____ Hispanic ____Non-Hispanic				( ) -	
Chose clinic because/Referred to clinic by:		❑ Dr.		❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ ZOCDOC	OTHER:	

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone number ( )	Cell phone number ( )

The above information is true to the best of my knowledge.

Patient/Guardian SIGNATURE →: _____ Date: _____

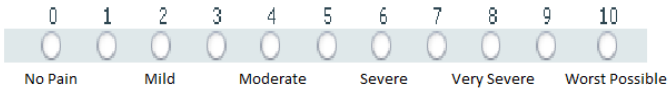
GILBERT MEDICAL GROUP
FAMILY DOCTOR TODAY.COM
NEW ADULT PATIENT HISTORY FORM

LAST NAME FIRST NAME DATE

DATE OF BIRTH HT WT

CHIEF COMPLAINT (REASON FOR TODAY'S VISIT): _____

PAIN SCALE:



DETAILS OF PRESENT ILLNESS: _____

PAST MEDICAL HISTORY (CURRENT MEDICAL CONDITIONS and date diagnosed or suspected): _____

LIST ALL MEDICATIONS CURRENTLY TAKING (include dosage and times taken during the day or if taking as needed):

(Drug Name)	(Dosage)	(Times Taken per day)	(Diagnosis – taken for what illness)

LIST ALL KNOWN DRUG ALLERGIES AND YOUR REACTION TO THEM:

(Allergy)	(Reaction)

SURGICAL HISTORY (include dates): _____

FAMILY HISTORY: (LIST ALL MEDICAL PROBLEMS OF PARENTS, SIBLINGS, CHILDREN, AND GRANDPARENTS):

Relative	Medical Problem

Diagnostic Procedure/ Health Screening	Date	Normal	Abnormal (describe abnormality)
Echocardiogram			
EKG			
Mammogram			
Colonoscopy/Sigmoidoscopy			
Eye exam			
Dental Visit			
Bone density			
Rectal Exam			
Prostate exam			
MRI			
CT scan			
Ultrasound			
Bloodwork			
XRAY			

PREVIOUS HOSPITALIZATIONS: _____

CURRENT SPECIALISTS NAMES, PHONE NUMBERS AND FAX NUMBERS: _____

USE THIS AREA TO EXPLAIN ANSWERS TO REVIEW OF SYMPTOMS ON PAGE 3 (NEXT PAGE) _____

SOCIAL HISTORY:

ALCOHOL USE IN PAST YEAR ☐ YES ☐ NO
IF YES, HOW OFTEN DAILY _____

SMOKE ☐ CURRENT SMOKER ☐ CURRENT EVERY DAY SMOKER ☐ CURRENT SOME DAY SMOKER
☐ FORMER SMOKER Age when Started_____ Age when stopped_____
☐ NONSMOKER
Cigarettes per day _____. Years/Months smoking _____

RECREATIONAL DRUGS (Drugs not prescribed to you or illicit drugs)
☐ YES ☐ NO
IF YES, TYPE & HOW OFTEN DAILY, HOW MANY YEARS
_____
_____

Are you still using? _____

How many months ago did you stop using? _____

Are you in a treatment program? _____

CAFFEINE USE
☐ YES ☐ NO
IF YES, HOW OFTEN DAILY _____

ADDITIONAL INFORMATION:

Do you feel safe in your relationship?
Is violence at home a concern for you?
Are you sexually active?
If yes, do you practice safe sex / using protection (list type of protection)
Are your sexual partners male, female, or both?
Any past sexually transmitted infections? Please list and provide dates.
Do you use contraception and what type?
Who lives at home with you?
Have you felt sad or down in the last two weeks?
Have you lost interest in activities you usually enjoy?
How would you rate your overall level of health; 0 being "the worst possible" and 100 is "Great, no problems". Physical Health: _____ Mental Health _____
Recent Travel (List locations):

Review of Systems

GENERAL		
Fatigue	NO	YES
Weakness	NO	YES
Sweats at NIGHT	NO	YES
Fever	NO	YES
Sleep disturbance/ Difficulty sleeping	NO	YES

RESPIRATORY		
Shortness of breath at rest	NO	YES
Shortness of breath with exertion	NO	YES
Emphysema/ Bronchitis/COPD	NO	YES
Asthma	NO	YES
Cough	NO	YES
Coughing Blood	NO	YES

EYES		
Double vision	NO	YES
Blurred vision	NO	YES
Discharge	NO	YES
Dry eye	NO	YES
Pain	NO	YES
Red eye	NO	YES
Itching	NO	YES

EARS/ NOSE/ THROAT		
Stuffiness	NO	YES
Hoarseness	NO	YES
Blocked ear	NO	YES
Hearing loss	NO	YES
Trouble swallowing	NO	YES
Dry mouth	NO	YES
Earache	NO	YES
Nose Bleeds	NO	YES
Ringing in the ears	NO	YES
Sinus Pain	NO	YES
Sore throat	NO	YES
Swollen glands	NO	YES

NEUROLOGICAL		
Headache	NO	YES
Dizziness	NO	YES
Fainting	NO	YES
Seizures	NO	YES
Memory loss	NO	YES

CARDIOVASCULAR		
Anemia	NO	YES
Blood clots	NO	YES
Leg/ ankle swelling	NO	YES
Palpitations	NO	YES
Chest pain at rest	NO	YES
Chest pain with exertion	NO	YES

MOUTH		
Ulcers	NO	YES

GASTROINTESTINAL		
Weight loss	NO	YES
Weight gain	NO	YES
Hepatitis	NO	YES
Hernias	NO	YES
Anal/rectal pain	NO	YES
Anal/rectal bleeding	NO	YES
Change in appetite	NO	YES
Fecal incontinence	NO	YES
Abdominal pain	NO	YES
Blood in stool	NO	YES
Constipation	NO	YES
Diarrhea	NO	YES
Heartburn	NO	YES
Nausea	NO	YES
Vomiting	NO	YES

MENTAL HEALTH		
Depression	NO	YES
Anxiety	NO	YES

GENITOURINARY		
Painful urination	NO	YES
Frequent urination	NO	YES
Waking up at night to urinate	NO	YES
Kidney stones	NO	YES
Blood in urine	NO	YES

GYNECOLOGICAL-Female Only		
Number of pregnancies		
Number of births _____		
C-section	NO	YES
Abortion(s)	NO	YES
Miscarriage(s)	NO	YES
Length of each period		
Last Menstrual Period		
Last Pap Smear		
Age of First Period		
Cycle length (days)		
Pelvic pain	NO	YES
Breast lumps	NO	YES
Nipple discharge	NO	YES
Heavy bleeding	NO	YES
Vaginal Discharge	NO	YES

MUSCULOSKELETAL		
Back pain	NO	YES
Joint pain	NO	YES

SKIN		
Rash	NO	YES
Nodules	NO	YES

I certify the above information is true and accurate to the best of my ability:

Patient/Guardian Signature: _____ Date: _____