Orono Family Medicine

Patient Registration

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Best Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M F Marital Status S M D W

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*While we do not accept insurance payment, we will provide a receipt for personal reimbursement or  
 payment toward deductible.*

*\*\*Payment is due at time of service. For other arrangements, please speak to Dr. Smith.*

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Orono Family Medicine

Patient Health History Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor/Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you seeing the doctor today?

Was this condition related to a **work** injury? **YES NO** If yes, what date did the injury occur? \_\_\_\_\_\_\_\_\_\_\_\_

Was this condition related to an **auto** accident? **YES NO** If yes, what date of the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_

Was this related to any **other** type of injury? **YES NO** Describe the injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated elsewhere for this condition**? YES NO** If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past History

LIST ALL PREVIOUS HOSPITALIZATIONS OR SURGERIES (& DATES):

LIST MEDICAL PROBLEMS AND CONDITIONS THAT YOU HAVE HAD OR CURRENTLY HAVE (& DATES):

Medications

LIST MEDICATIONS YOU ARE CURRENTLY TAKING [name, dosage (mg) & frequency]:

Allergies

LIST ALLERGIES TO ANY MEDICATIONS, LATEX OR OTHER MATERIALS? PLEASE LIST

TYPE OF REACTION

 rash  hives  severe reaction  intolerance  anaphylaxis  other (please state what the reaction is/was):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Habits

Do you use tobacco in any form? YES NO If yes, how much and what?

Did you used to smoke? YES NO If Yes when did you quit?

Do you drink alcohol? YES NO If yes, how much?

Have you ever used IV drugs? YES NO

Do you use herbs, vitamins or nutritional supplements? YES NO If yes, please list them:

Family History

Do you have a family history of arthritis or disease of the muscles, bones or nervous system? YES NO

If yes, please describe:

Do you have a family history of cancer? YES NO If yes, please describe:

Do you have a family history of bleeding/clotting problems? YES NO

If yes, please describe:

Do you have a family history of any other diseases you would like to discuss with your doctor? YES NO

If yes, please describe:

Employment/Social History

Are you currently employed? YES NO If yes, what is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your work  HEAVY  MEDIUM  LIGHT  SEDENTARY

Do you have any current work restrictions? YES NO

If yes, please describe:

What is your marital status?  SINGLE  MARRIED  WIDOWED  DIVORCED OR SEPARATED

Any Children? If so, please list ages:

Who lives with you? Pets?

Review of Systems

DO YOU CURRENTLY HAVE PROBLEMS IN THE FOLLOWING AREAS?

General YES NO Digestive YES NO

Ears, Nose, Throat YES NO Skin YES NO

Eyes YES NO Neurological YES NO

Cardiovascular YES NO Psychiatric YES NO

Respiratory YES NO Endocrine YES NO

Urinary, Kidney, Bladder YES NO Blood/Lymph YES NO

Muscle, Bones, Joints YES NO Allergic/Immune YES NO

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_