Creelman Family Practice, PLLC

IMMIGRATION PATIENT REGISTRATION

Today's Date_____

PATIENT

First Name	**Middle Name**	**Last Name**	**Maiden Name**

Age _____ **Birthdate** _____/_____/_____ □ **male** □ **female** **Social Security #** _____ **/** _____ **/** _____

Street Address _____ **City**_____ **State**_____ **Zip**_____

Mailing Address if different from above _____

Home Phone _____ **Cell Phone** _____ **Other** _____

RESPONSIBLE PARTY: PARENTS/GUARDIAN/SPOUSE

First Name	**Middle Name**	**Last Name**	**Relationship**

Street Address _____ **City**_____ **State**_____ **Zip**_____

Mailing Address if different from above _____

Home Phone _____ **Cell Phone** _____ **Other** _____

FINANCIAL AGREEMENT:

Charges for the Immigration Physical Exam, additional Laboratory Services, Document Review or mailing services are the sole responsibility of the Responsible Party (as noted above: patient/guardian/spouse). Any balance owing for the exam or additional costs incurred are due at the time of service by cash or credit card only. We do not bill medical insurance or provide HCFA insurance information for these services. You will be provided a receipt for charges paid.

I acknowledge that I understand and accept this financial responsibility and that all questions were answered to my satisfaction.

Signature _____ **Date**_____

Creelman Family Practice, PLLC

IMMIGRATION PATIENT PERSONAL INFORMATION

Today's Date_____

Confidential information is not released without your authorization

Name _____ Age _____ Birthdate ____/ ____/ ____

Marital Status □ single □ married □ divorced □ separated □ widowed
Occupation (if retired list previous occupation) _____
Recent Doctor(s) _____Last Exam Date _____

Wish to share your medical record with a family member? □ yes □ no Name _____ Relationship _____

Previous Surgery (month/year) □ check if none

_____ _____ _____
_____ _____ _____

Other Surgeries, Hospitalizations or Major Illnesses *List any ongoing medical conditions*

_____

_____

Current Medication and Supplements (prescribed and over the counter) *Please list dosage*

name_____ name_____
name_____ name_____
name_____ name_____

Allergies (meds, foods, seasonal) _____

_____

Weight Average last 5 years _____

Smoking History of smoking? □ yes Packs a day_____ Year first started_____ Date quit _____ Desire to quit? □ yes □ no

Alcohol Do you drink alcohol? □ yes □ no Average # of drinks _____ □ day □ week □ month □ year

Ever felt you should cut down on your drinking? □ yes □ no Felt annoyed by others criticizing your drinking? □ yes □ no
Morning drink to steady nerves or rid of a hangover?□ yes □ no Felt bad or guilty about your drinking? □ yes □ no
Have you ever been arrested or convicted of an alcohol related crime? □ yes □ no

Drugs Street drugs ever used? □ yes □ no □ currently using Ever wanted help to quit? □ yes □ no

Chronic use of pain medication? □ yes □ no □ currently using Ever wanted help to quit? □ yes □ no

name_____ frequency_____

name_____ frequency_____

Mental Health Have you ever been diagnosed or treated for a mental health problem such as:

Major depression □ yes □ no Schizophrenia □ yes □ no Anxiety □ yes □ no Bipolar Disorder □ yes □ no
Have you ever had thoughts of harming yourself or someone else? □ yes □ no

PLEASE CONTINUE FORM ON NEXT PAGE

Family Health History

	Age if living	Age at death	Major illnesses
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
# ___	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
# ___	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please indicate illnesses of relatives including aunts, uncles, cousins, grandparents:

alcoholism_____ mental health_____
tuberculosis_____ chronic cough_____

Past Month Health History *Circle any of the symptoms which have troubled you in the past **month**.*

Pain in your stomach, back, arms, legs, joints, headache
Chest pain
Fainting Spells
_____
_____
_____

Eating out of control
Little interest or pleasure in doing things
Depressed, feeling down, hopeless, tearful
Nervous, anxious, on edge, explosive
Worrying about many things
Anxiety attacks, sudden panicky feeling

Past Year Health History *Circle any of the symptoms which have troubled you in the past **year.***

Unexplained fever, chills, sweats, bleeding, rashes
Weight change
Eating issues causing vomiting or diarrhea
Memory loss, poor balance, difficult speech
Weakness in arms or legs left or right
Blurred vision not eyeglass corrected
Double vision, light flashes, visual loss, halos, eye pain
Swollen glands, unexplained lumps steadily enlarging
Swollen joints, painful joints
Changing moles
Increased thirst
Too cold or warm most of the time

Frequent heart flutters or unusual heart beats
Snoring, pauses in breathing when asleep
Decreasing exercise ability
Ankle swelling, leg cramps with walking
Wheezing
Cough lasting over one month
Night sweats
Change in bowel habits
Rectal bleeding, black stools
Bloody urine
_____
_____

Women

Persistent vaginal discharge
Date of last period _____
Last pap smear _____
History of STD (sexually transmitted disease)
History of multiple sexual partners
Are you pregnant or trying to become pregnant? □ yes □ no
Birth control method _____
Number of living children _____

Men

Sores or discharge from penis
Lump in testicle
History of STD (sexually transmitted disease)
History of multiple sexual partners