LAKE FOREST
ACUTE CARE

REGISTRATION FORM

Patients last name:	**First:**	**Middle:**	**SS#** ___ ___ ___-___ ___-___ ___ ___ ___
Birth Date: ________ /_________ /___________	**Sex** □ Male □ Female	**Marital status (circle one):** Single/ Married/ Divorced/ Separated/ Widow/ Child	
Street address:	PO Box:	**Primary Phone:** ( )	
City:	**State:**	**Zip Code:**	**Secondary Phone:** ( )
Pharmacy:	**Zip Code/ City & Intersection:**		
How did you find our office? □ Friend □ Relative □ Doctor □ CVS/ Walgreens □ ZocDoc □ Insurance Directory □ Internet □ Mailer □ Newspaper □ Phonebook □ Sign □ Work □________________________	**Email:**		

Race: □ American Indian/ Native Alaskan □ Black /African American □ Asian □ Native Hawaiian/other Pacific Islander □ White □ Decline

Ethnicity: □ Hispanic/ Latino □ Not Hispanic/Latino □ Decline

Person Responsible for Bill (if someone other than patient):

Name: Address:

Birthdate:

Relationship to patient: Phone Number: ( )

Primary Care Doctor (optional):	**Emergency Contact**:
Address:	Relationship to patient:
Phone number: ( )	Address:
Fax: ( )	Primary Phone: ( )

Work Related Visits only:

Employer:	Position:
Reason for visit: □ pre-employment □ Injury:____	

Patient History Form

Patient Name:_______________________________________

Date of Birth:________/________/_________________

Reason for Visit:

____

Office Use Only:

HR: ______________bpm RR:___________per minute

O2:_____________% Temp.___________°

BP:____________/_____________

Visual Acuity:

L: __________/__________ corrected/ uncorrected

Allergies: ☐ **No** ☐ **Yes:**

Please List:	Type of Reaction (ie. Rash, Hives, Nausea)
______________________________	______________________________________
______________________________	______________________________________
______________________________	______________________________________

Current Medications (Include Over the Counter) :

Name	Dose	Frequency (Ex. Daily)
__________________________________	________	_________________________
__________________________________	________	_________________________
__________________________________	________	_________________________
__________________________________	________	_________________________
__________________________________	________	_________________________
__________________________________	________	_________________________

Weight___________Height___________ **Last Menstrual Period ____/_____/____** ☐ **Menopause**

Pregnant: ☐ **No** ☐ **Yes, Due date: ____/_____/____**

Medical History:

☐ Arthritis	☐ Genitourinary	☐ Lung Problems
☐ Blood Disorder	☐ Heart Problems	☐ Musculoskeletal
☐ Cancer	☐ High Cholesterol	☐ Sexually Transmitted Disease
☐ Diabetes	☐ High Blood Pressure	☐ Skin Disorder
☐ Ear/Nose/Throat	☐ Kidney Problems	☐ Stroke/Seizures/Neurological
☐ Gastrointestinal	☐ Liver Problems	☐ Other___________________________
☐ Thyroid		

Surgeries:

Head/Neck/Breast ________________________________ Abdominal/Pelvic __________________________________

Bone/Joint _______________________________________ Spine ____

Heart/Lung ______________________________________ Other____

Social History:

Use of Tobacco: ☐ Never ☐ Former Daily: ☐ < 1 Pk ☐ > 1 Pk How many years _________

☐ Smokeless Tobacco

☐ Use Street/Un-prescribed Drugs ___________________

☐ Recent Travel _____________________________________ Education (Grade/Degree)

____

☐ Exercise? How often?______________________________ Sexually Active ☐ Yes ☐ No

Use Alcohol ☐ Never ☐ Rarely Drinks per day ☐ < 1 ☐ 1-2 ☐ 2-3 ☐ >3

Living Status:

☐ Married ☐ Single ☐Widow ☐ Divorced

☐ Live Alone ☐ Live with S.O. ☐ Parents ☐ Other ______________________

Family History:

	Heart Disease	Cancer	Other
Father	☐	☐	☐__________________________
Mother	☐	☐	☐__________________________
Brother	☐	☐	☐__________________________
Sister	☐	☐	☐__________________________