



Family Practice Center, Inc. – Patient Registration Sheet

Family History – Please check box if applicable

	Father	Mother	Father's Parents	Mother's Parents	Children
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Glaucoma					
Diabetes					
Epilepsy/Seizure					
Bleeding Disorder					
Kidney Disease					
Thyroid Disease					
Mental Illness					

Past Medical History

- | | | |
|---|---|--|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Gall Bladder Dx _____ | <input type="checkbox"/> Chronic Rashes _____ |
| <input type="checkbox"/> Shortness of Breath _____ | <input type="checkbox"/> Prostate Disease _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Heart Palpitations _____ | <input type="checkbox"/> Bowel Irregularity _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Heart Murmur _____ | <input type="checkbox"/> Sexual/Menstrual Prob. _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Chest Pain _____ | <input type="checkbox"/> STDs _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Dizziness/Fainting _____ | <input type="checkbox"/> Frequent Infections _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Peripheral Vascular Dx _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Depression _____ | _____ |
| <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Gout _____ | _____ |
| <input type="checkbox"/> GI Disorder _____ | <input type="checkbox"/> Scarlet Fever _____ | _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Arthritis _____ | _____ |

Hospitalization or Surgery Record

Reason	Date	Reason	Date

Medication Allergies

Medication Name	Reaction

Immunizations: Last Tetanus: _____ Pneumonia: _____ Flu Vaccine: _____ Other: _____

Patient/Guardian Signature: _____ **Date:** _____

Print Name of Patient: _____