

Integrative Medicine & Acupuncture, P.C.
KAREN KAN, MD

PATIENT REGISTRATION FORM

NAME: _____ DATE OF BIRTH: _____
 ADDRESS: _____ TOWN _____ ZIP _____
 HOME PHONE: _____ CELL OR WORK PHONE: _____
 EMAIL ADDRESS (optional): _____
 SOCIAL SECURITY NUMBER: _____
 NAME OF PRIMARY PHYSICIAN: _____
 NAME OF SPECIALISTS: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relation: _____
 Home Phone: _____ Work Phone: _____

HEALTH & FAMILY HISTORY

1. Do you or any of your family members have/had the following health problems?

Health Problem:	You – when diagnosed?	Family Member – who?
Alcoholism		
Allergies (environmental)		
Arthritis		
Cancer (what type?)		
Diabetes		
Digestive Problems		
Drug Addiction		
Eye Disease (e.g.Glaucoma)		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Lung Disease/Asthma		
Mental Health Problems		
Migraine/headaches		
Reflux/Heartburn		
Sinus Infections		
Skin Problems		
Stroke		
Thyroid Disease		
Other _____		

2. Is anyone in your immediate family deceased? If yes, please state cause of death:

3. Please list any medication **ALLERGIES** and the type of reaction you had:

4. Please list any hospitalizations/surgeries and the approximate dates:

Reason for Hospitalizations/Surgeries:	Dates:

5. Please list any medications you are currently taking, including over the counter supplements, herbs and vitamins (use back of form if necessary):

Name:	Dosage & Frequency:

SOCIAL HISTORY

6. Check which substances you use and describe how much you use them:

- Alcohol _____
- Caffeine _____
- Drugs _____
- Tobacco _____ Quit Date: _____

7. Marital Status: _____

8. Occupation: _____

9. Number of Children, if any: _____

PREVENTIVE CARE HISTORY

10. When was your last complete physical exam/check-up? _____

11. When was your last Tetanus shot? _____

12. If you are over age 50, when was your last Flu shot? _____

13. If you are over age 50, have you had colon cancer screening? _____

14. If you are a woman, when was your last pap smear? _____

15. If you are a woman over age 50, when was your last mammogram? _____

16. Do you consistently wear your seatbelt while in a car? Y N

Patient/Parent Signature: _____ Date: _____

Dr Kan's Signature: _____