Dowlen Medical Center
REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital Status:

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:

Address:		
SSN:	Home #:	Cell #:
Occupation:	Employer:	Employer #:

Chose Clinic because/ referred by (option):

Other family members seen here:

Insurance Information

Please give your insurance card to the receptionist

Person responsible for bill:	Birth date:	Address if different:	Home #:

Is this person a patient here?		Is this patient covered by insurance?	
Occupation:	Employer:	Employer address:	Employer #:

Please indicate primary insurance:[choose and item]other:[other insurance]

Subscriber's name :	Subscriber's SSN:	Birth date:	Group #:	Policy#:

Patient's relationship to subscriber:

Name of secondary insurance(if applicable):	Subscriber name:	Group #:	Policy #:

Patient's relationship to subscriber:	Other:

IN CASE OF EMERGENCY

Name of local friend or relative(not living at the sane address)	Relationship to patient:	Home phone #:	Work phone:

I hereby authorize and give my consent for medical treatment and procedures by Shama Quraishi, M.D. I also authorize Shama Qurashi, M.D. To release any medical information in connection with services rendered for health insurance purposes or the patient's personal physician. I authorize my insurance company to pay any benefits directly to Shama Ourashi, M.D. I also agree to pay by check, cash or credit card for any copay amounts and any services rendered by Shama Ouraishi M.D. Not covered by my insurance company, if applicable. I understand that this office requests a 5 day notice on refill request whenever possible.

Parent/Guardian signature **Date**

Dowlen Medical Center
Patient History Form

Patient's Name:_____ **Today's Date:**_____

Social Security Number:_____ **Date of Birth:**_____

Past Medical History

Previous Physician's Name:_____ Date of last exam:_____

Have you ever been hospitalized:_____ If yes, what for?_____

Have you ever been tested for hepatitis A, B, or C? ☐ Yes ☐ No Which hepatitis virus_____

Have you ever been vaccinated for hepatitis B? ☐Yes ☐No If yes, date vaccine series completed_____

Have you ever been vaccinated for hepatitis A? ☐Yes ☐No If yes, date vaccine series completed_____

Last Tuberculosis(TB) Screening?_____ Result of TB Screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray:_____ Result of chest x-ray : ☐Positive ☐Negative

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis:_____

Which of the following conditions are you currently being treated or have been treated for in the past (Please Check)

☐Heart disease/ Murmur/ Angina	☐ Shortness of breath	☐Eye disorder/ Glaucoma	☐Diabetes
☐High Cholesterol	☐Asthma	☐Seizures	☐Kidney/Bladder problems
☐High Blood Pressure	☐Lung Problems/ Cough	☐Stroke	☐Liver problems/Hepatitis
☐Low Blood Pressure	☐Sinus Problems	☐Headaches/Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological Problems	☐Cancer
☐Anemia or Blood Pressure	☐Tonsillitis	☐Depression/Anxiety	☐Ulcers/Colitis
☐Swollen Ankles	☐Ear Problems	☐Psychiatric Care	☐Thyroid problems

Please describe any current or past medical not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No

Please list:_____

Medications

Please list:_____

Social and Preventative History

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No

How many packs per day?_____

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No

How many drinks per week?_____

Do you currently drink coffee and or / tea? ☐Yes ☐No If yes, how many cups per day? ☐Yes ☐No

Do you exercise daily/ weekly? ☐Yes ☐No

Do you use seat belts while driving? ☐Yes ☐No Do you wear helmet while riding a bike?☐Yes ☐No

Family History

Living		Age(or age at death)	List serious illness
Mother	☐Yes ☐No	_____	_____
Father	☐Yes ☐No	_____	_____
Sisters	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
Brothers	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness Which family member?

Anemia or Blood disease _____

Cancer _____

Glaucoma_____

Heart Disease_____

High Blood Pressure_____

HIV disease/ AIDS_____

Mental illness/ Depression_____

Stroke_____

Other serious illness_____

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear_____

Have you had an abnormal Pap Smear? ☐Yes ☐No Diagnosis:_____Follow up:_____

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: _____

Date of last mammogram:_____ Mammogram results:_____

Have you ever had a breast biopsy? ☐Yes ☐No Biopsy results:_____

By signing below, I hereby certify to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature_____Date_____

CONFIDENTIAL PATIENT HEALTH HISTORY

Pt. Name:_____Today's Date_____Previous Doctor_____

Birth Date:_____Age:_____Date of last physical:_____

Have you signed an advance directive? Y N If no, would you be interested?_____

SYMPTOMS- Check symptoms are you currently having or have had in the past year:

GENERAL

__Chills
__Depression
__Dizziness
__Fainting
__Fever
__Forgetfulness
__Headache
__Loss of Sleep
__Loss of Weight
__Nervousness
__Numbness

MUSCLE/JOINT BONE

Pain, Weakness, numbness in:
__Arms __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders

GENITO-URINARY

__Blood in Urine
__Frequent Urination
__Lack of Bladder Control
__Painful Urination

GASTROINTESTNAL

__Poor Appetite
__ Bloating
__Bowel Changes
__Constipation
__Diarrhea
__Excessive Hunger
__Excessive Thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal Bleeding
__Stomach Pain
__Vomiting Blood

CARDIOVASCULAR

__Chest Pain
__High Blood Pressure
__Irregular Heart Beat
__Low Blood Pressure
__Poor Circulation
__ Rapid Heart Beat
__Swelling of Ankles
__Varicose Veins

EYE.EAR,NOSE,THROAT

__Bleeding Gums
__Blurred Vision
__Crossed Eyes
__Difficulty Swallowing
__Double vision
__Earache
__Ear Discharge
__Hay Fever
__Hoarseness
__Loss of Hearing
__Nose Bleeds
__Persistent Coughs
__Ringing in Ears
__Sinus Problems
__Vision-Flashes-Halos

SKIN

__Bruise Easily
__Hives
__Itching
__Change in Moles
__Rash
__Scars
__Sore that wont heal

MALES ONLY

__Erection Difficulties
__Lump in Testicles
__Penis Discharge
__Sore on Penis

FEMALES ONLY

__Abnormal pap
__Abnormal Bleeding
__Breast lump
__Extreme Menst. Pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Vaginal Discharge
Did you go through Menopause? Age:
Date of last menstrual period:
_____
Date of last Paps_____
Have you ever had a Mammogram? Y N
If so when & where
_____
Are you pregnant? Y N

CONDITIONS:

__AIDS
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Bleeding Disorders
__Breast Lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Gonorrhea
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herpes
__High Cholesterol
__HIV Positive
__Kidney Disease
__Liver Disease
__Measles
__Migraine Headaches
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Pace maker
__Pneumonia
__Polio
__Prostate problem
__Psychiatric Care
__Rheumatic Care
__Scarlet Fever
__Stroke
__Suicide Attempt
__Tonsillitis
__Tuberculosis
__Typhiod Fever
__Ulcers
__Vaginal Infections
__Venereal Disease

ALLERGIES:

_____