mirus MEDICAL Dr. Danielle Hamilton/Dr. Fan Mo

New Patient Registration Form

Patient Name:_____ **DOB:** _____ **Gender:** ☐**M** ☐**F**

Address:_____

Phone Number:

Cell: _____ **Home:**_____ **Work:** _____

email: _____

Past Medical History: (have you ever had the follow conditions, please check yes or no)

	Yes / No		Yes / No		Yes / No
Heart disease	☐ ☐	**High Blood Pressure**	☐ ☐	**Irregular heart beat**	☐ ☐
Diabetes	☐ ☐	**Stroke**	☐ ☐	**Kidney disease**	☐ ☐
Blood clots	☐ ☐	**Depression/Anxiety**	☐ ☐	**High cholesterol**	☐ ☐
Cancer	☐ ☐	**Autoimmune conditions**	☐ ☐	**Hepatitis**	☐ ☐
Asthma/COPD	☐ ☐	**Glaucoma**	☐ ☐	**AIDS/HIV**	☐ ☐
Stomach Ulcer	☐ ☐	**Thyroid disease**	☐ ☐	**Skin conditions**	☐ ☐
Arthritis	☐ ☐	**Anemia**	☐ ☐	**Chronic infection**	☐ ☐

If you answered 'Yes' to any questions above, please provide details regarding investigations, specialist appointments, and treatments:

_____

_____

_____

Please list all other medical problems/illnesses that you are seeing or have seen a physician for:

_____

_____

_____

Past Surgical History:

Date:_____**Surgery:**_____

Date:_____**Surgery:**_____

Date:_____**Surgery:**_____

Medication list:

_____

_____

_____

_____

Allergies to Medications/Environmental: _____

Family History:

	Yes / No		Yes / No		Yes / No
Heart disease	☐ ☐	**High Blood Pressure**	☐ ☐	**Thyroid disease**	☐ ☐
Diabetes	☐ ☐	**Stroke**	☐ ☐	**Kidney disease**	☐ ☐
Blood clots	☐ ☐	**Depression/Anxiety**	☐ ☐	**High cholesterol**	☐ ☐
Cancer	☐ ☐	**Autoimmune condition**	☐ ☐	**Skin cancer**	☐ ☐
Asthma/COPD	☐ ☐	**Glaucoma**	☐ ☐		

If you answered 'Yes' to any questions above, please provide details regarding family member(s), diagnosis, age at diagnosis and/or death:

_____

_____

_____

Social History:

Occupation: _____

Insurance coverage for medications: ☐ Yes ☐ No

Marital Status: Single / Married / Divorced; Number of Children: _____

Alcohol consumption: _____drinks/week

Smoking: ☐ Yes ☐ No If Yes, number of cigarettes per day _____, for _____ years.

Your Pharmacy:_____

Health Screening:

When was your most recent annual physical exam: _____

Last Tetanus shot: _____

If applicable:

Most recent pap smear:_____ Most recent Mammogram: _____

Colonoscopy or FOBT test: _____ Bone Mineral Density: _____

PSA testing: _____

Patient Signature: _____