ROMEO MEDICAL CLINIC
1801 COLORADO AVE SUITE 120 TURLOCK, CA 95382
TELEPHONE (209) 216-3456 FAX (209) 216-3462

PATIENT REGISTRATION SHEET

PATIENT LAST NAME _____ FIRST NAME _____

ADDRESS_____ CITY_____ STATE_____

ZIP CODE_____TELEPHONE _____ MOBILE_____

DATE OF BIRTH_____AGE_____SEX_____ MARTIALSTATUS_____

SOCIAL SECURITY # _____ E MAIL _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS_____ EMPLOYER'S PHONE _____

PREFERRED PHARMACY_____ EMERGENCY CONTACT _____

IF PATIENT IS UNDER 18, RESPONSIBLE PARENT/GUARDIAN

PARENT/GUARDIAN NAME _____ RELATIONSHIP _____

PARENT/GUARDIAN HOME PHONE _____ MOBILE _____

PRIMARY INSURANCE INFORMATION

(PLEASE PROVIDE COPY OF INSURANCE CARD)

INSURANCE COMPANY _____ ID#_____ GROUP# _____

CLAIMS ADDRESS_____ EFF DATE _____

NAME OF INSURED_____ DOB _____ SSN _____

INSURED'S ADDRESS_____ INSURED'S PHONE _____

INSURED'S EMPLOYER _____ EMPLOYER'S PHONE _____

EMPLOYER'S ADDRESS_____

SECONDARY INSURANCE INFORMATION

(PLEASE PROVIDE COPY OF INSURANCE CARD)

INSURANCE COMPANY _____ ID#_____ GROUP# _____

CLAIMS ADDRESS_____ EFF DATE _____

NAME OF INSURED_____ DOB _____ SS# _____

INSURED'S ADDRESS_____ INSURED'S PHONE _____

INSURED'S EMPLOYER _____ EMPLOYER'S PHONE _____

EMPLOYER'S ADDRESS_____

I hereby authorize the release of any medical information to insurance carriers to process a claim and request payment either to myself or to Romeo Medical Clinic for medical services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE.**

SIGNATURE _____ DATE _____

PATIENT HISTORY FORM (ADULT 18+)

NAME: _____ DOB: _____

MEDICATIONS & ALLERGY SUMMARY

DO YOU HAVE ANY ALLERGIES THAT YOU KNOW OF (INCLUDING SEASONAL)? ☐YES ☐NO

MEDICATION ALLERGIES? ☐YES ☐NO

Which medications are you allergic to?

_____

_____

What kind of reaction do you have?

_____

FOOD ALLERGIES? ☐YES ☐NO

What food(s) are you allergic too?

_____

_____

What kind of reaction do you have?

_____

SEASONAL ALLERGIES? ☐YES ☐NO

What kind of reaction do you have?

_____

_____

CURRENT MEDICATIONS

Are you currently taking any medication *(daily or as needed - prescribed, over-the-counter, vitamins, supplements)*? ☐YES ☐NO

If yes, list name of medication(s):_____

_____

PAST MEDICAL HISTORY

DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY MEDICAL PROBLEM(S) OR INJURIES INVOLVING YOUR:

SKIN? ☐YES ☐NO

- ☐acne
- ☐alopecia
- ☐eczema
- ☐herpes
- ☐hives
- ☐nail infection
- ☐precancerous skin lesion
- ☐psoriasis
- ☐rosacea
- ☐seborrheic dermatitis
- ☐warts
- ☐other _____

HEAD OR NECK? ☐YES ☐NO

- ☐Bells palsy
- ☐concussion
- ☐goiter
- ☐TMJ disorder
- ☐other _____

EAR(S)? ☐YES ☐NO

- ☐eustachian tube function
- ☐hearing loss
- ☐other _____

EYE(S)? ☐YES ☐NO

- ☐cataract
- ☐glaucoma
- ☐other_____

NOSE? ☐YES ☐NO

- ☐allergic rhinits
- ☐chronic sinusitis
- ☐other_____

THROAT/MOUTH? ☐YES ☐NO

- ☐recurrent strep throat
- ☐other_____

TEETH/GUMS? ☐YES ☐NO

- ☐other _____

BREAST(S)? ☐YES ☐NO

- ☐abnormal mammogram
- ☐mastitis
- ☐fibrocystic disease
- ☐fibroadenosis
- ☐other _____

LUNGS OR BREATHING? ☐YES ☐NO

- ☐asthma (allergy)
- ☐asthma (non allergy)
- ☐emphysema
- ☐croup
- ☐COPD
- ☐sinusitis
- ☐other _____

HEART, ARTERIES OR VEINS? ☐YES ☐NO

- ☐angina
- ☐atrial fibrilation
- ☐heart disease
- ☐heart failure
- ☐heart attack
- ☐high blood pressure
- ☐"mini stroke"
- ☐pulmonary embolism
- ☐tachycardia
- ☐other _____

STOMACH OR ABDOMEN? ☐YES ☐NO

- ☐anemia
- ☐Crohns disease
- ☐diverticulosis
- ☐diverticulitis
- ☐gallbladder disease
- ☐gastroesopho-geal reflux (GERD)
- ☐hernia
- ☐irritable bowel syndrome
- ☐ulcer
- ☐ulcerative colitis
- ☐other _____

BLADDER, KIDNEYS OR GENITALS? ☐YES ☐NO

- ☐cervical polyp
- ☐genital herpes
- ☐kidney disease
- ☐kidney stones
- ☐BPH (with obstruction)
- ☐ovary cysts
- ☐BPH (without obstruction)
- ☐recurrent bladder infections
- ☐other _____

PAST MEDICAL HISTORY (CONTINUED)

MUSCLE(S), BONE(S) OR JOINT(S)? ☐YES ☐NO

☐scoliosis ☐fibromyalgia ☐gout ☐lupus ☐carpal tunnel ☐osteoarthritis
☐osteoporosis ☐rheumatoid arthritis ☐fracture_____
☐other _____ _____ _____

BRAIN OR NERVES? ☐YES ☐NO

☐Bells Palsy ☐carpal tunnel ☐concussion ☐migraine
☐Parkinsons ☐seizures ☐sleep apnea
☐other _____ _____ _____

BLOOD OR CANCER? ☐YES ☐NO

☐anemia
☐cancer (list type) _____
☐other _____

HORMONES/METABOLISM? ☐YES ☐NO

☐Diabetes (insulin injections) ☐Diabetes (no insulin)
☐high cholesterol ☐over active thyroid ☐under active thyroid
☐goiter ☐other _____ _____ _____

MENTAL STATE? ☐YES ☐NO

☐alcohol abuse ☐Alzheimer's ☐anxiety ☐dementia
☐depressive disorder ☐drug abuse ☐insomnia
☐other _____ _____ _____

HAVE YOU EVER HAD ANY OF THESE INFECTIONS?

☐measles ☐mumps ☐chickenpox ☐scarlet fever ☐diptheria
☐AID or HIV ☐mono ☐smallpox ☐whooping cough
☐recurrent bladder infections

TETANUS STATUS

☐ < 5 years ☐ > 10 years ☐ 5-10 years ☐ unknown

RISK FACTORS

TOBACCO USE

☐never smoked
☐former smoker
Age Started: _____
Age Quit: _____
Packs/Day: _____
☐current every day smoker
☐current occasional smoker
Age Started? _____
Packs of cigarettes/day: _____
Number of cigars/week: _____
☐use smokeless tobacco
Amount of chew/day: _____
☐passive smoke exposure

ALCOHOL USE

Average number of drinks:
☐0 ☐<1 ☐1 ☐2 ☐3 ☐4 ☐4+

Per:
☐day ☐month ☐week ☐year

Type
☐beer ☐wine ☐liquor

Have you ever?
☐felt the need to cut down
☐been annoyed by complaints
☐felt guilty about drinking
☐needed an a.m. "eye-opener"

DRUG USE

Current/history of drug use?
☐YES ☐NO
HIV high risk behavior?
☐YES ☐NO
List drugs used: _____
_____

SEATBELT USE

How often do you wear your seatbelt?
☐100%
☐75%
☐50%
☐25%
☐0%

SUN EXPOSURE

☐frequently
☐occasionally
☐rarely

CAFFEINE USE

How many drinks a day with caffeine?
☐0 ☐1 ☐3 ☐4

EXERCISE

How many times per week?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

Exercise Type
☐cycling
☐elliptical machine
☐running
☐swimming
☐treadmill
☐walking
☐other _____

OB/GYN (FEMALES ONLY)

Date of last PAP: ____ /____ /____
First period at age: _____
Age at menopause:_____
Menopause reasons/comments:
_____

☐currently pregnant
☐trying to get pregnant
☐not trying to get pregnant
☐unable to get pregnant

Type of contraception currently used:

☐condoms ☐diaphragm ☐OCP
☐IUD ☐tubal ligation ☐vasectomy

Check all that apply.

☐abortion without complications
☐postmenopausal hormone
☐ectopic pregnancy
☐stress incontinence
☐benign uterine fibroid
☐gestational diabetes
☐premenstrual tension syndrome
☐absence of periods
☐preeclampsia
☐pelvic inflammatory disease
☐abnormal pap smear
☐menopausal disorder
☐excessive menstruation
☐painful menstruation
☐cyst of ovary
☐endometriosis
☐complicated delivery
☐vaginal delivery

Total number of pregnancies: ____
Number of full-term pregnancies: ____
Number premature pregnancies: ____
Number of induced abortions: ____
Number of miscarriages: ____
Number of ectopic pregnancies: ____
Number of multiples: ____
Number of children living: ____

NAME: _____ DOB: _____

PAST SURGICAL HISTORY

HAVE YOU EVER HAD A PROCEDURE/SURGERY PERFORMED ON YOUR:

SKIN? ☐YES ☐NO

- ☐ removal of skin cancer
- ☐ removal of skin lesion
- ☐ skin grafting
- ☐ scar removal
- ☐ tatoo removal
- ☐ other _____

HEAD OR NECK? ☐YES ☐NO

- ☐ incision of trachea
- ☐ larynx removal
- ☐ sinus surgery
- ☐ thymus removal
- ☐ thyroid removal
- ☐ other _____

EARS? ☐YES ☐NO

- ☐ implanted hearing aids
- ☐ ear tubes
- ☐ ear drum repair
- ☐ other _____

EYES? ☐YES ☐NO

- ☐ cataract surgery
- ☐ lasik
- ☐ glaucoma surgery
- ☐ other _____

NOSE? ☐YES ☐NO

- ☐ repair of deviated septum
- ☐ sinus surgery
- ☐ turbinate bones removed
- ☐ other _____

THROAT/MOUTH? ☐YES ☐NO

- ☐ removal of tonsils
- ☐ removal of adenoids
- ☐ removal of larynx
- ☐ other _____

TEETH/GUMS? ☐YES ☐NO

- ☐ wisdom teeth extraction
- ☐ other

BREASTS? ☐YES ☐NO

- ☐ breast implants
- ☐ breast reduction
- ☐ mastectomy
- ☐ other _____

LUNGS? ☐YES ☐NO

- ☐ emergency airway puncture
- ☐ incision of trachea
- ☐ lung transplant
- ☐ removal of lung
- ☐ lung scope
- ☐ other _____

HEART, ARTERIES OR VEINS? ☐YES ☐NO

- ☐ stent
- ☐ bypass surgery
- ☐ heart valve repair
- ☐ other _____

STOMACH OR ABDOMEN? ☐YES ☐NO

- ☐ gastric bypass
- ☐ lap band
- ☐ removal of spleen
- ☐ removal of appendix
- ☐ removal of gallbladder
- ☐ C-Section
- ☐ hernia repair (groin)
- ☐ hernia repair (abdomen)
- ☐ other _____

BLADDER, KIDNEYS OR GENITALS? ☐YES ☐NO

- ☐ kidney removal
- ☐ kidney stone treatment
- ☐ ureter removal
- ☐ bladder removal
- ☐ removal of testicle(s)
- ☐ vasectomy
- ☐ tubes tied
- ☐ removal of uterus
- ☐ removal of ovaries
- ☐ adrenal gland removal
- ☐ hernia repair (groin)
- ☐ hernia repair (abdomen)
- ☐ other _____

MUSCLE(S), BONE(S), OR JOINT(S)? ☐YES ☐NO

- ☐ carpal tunnel release
- ☐ cubital tunnel release
- ☐ bunion removal
- ☐ ACL reconstruction
- ☐ low back surgery
- ☐ spine pathway enlargement
- ☐ ganglion cyst removal
- ☐ hip replacement
- ☐ herniated disc removal
- ☐ rotator cuff surgery
- ☐ total knee replacement
- ☐ knee surgery
- ☐ joint reconstruction
- ☐ other _____

BRAIN? ☐YES ☐NO

- ☐ brain aneurysm repair
- ☐ brain surgery
- ☐ other _____

HAVE YOU EVER HAD A PART OF YOUR BODY REMOVED? ☐YES ☐NO

(EXAMPLES: APPENDIX, TONSILS, GALLBLADDER)

EXPLAIN: _____

FAMILY HISTORY

WRITE THE NUMBER LOCATED NEXT TO EACH FAMILY MEMBER ON THE LINE BESIDE A CORRESPONDING CONDITION.

1 - MOTHER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

2 - FATHER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

3 - CHILDREN

living: ____
deceased: ____
Age at death: ____
Cause:_____

4 - SISTER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

5 - BROTHER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

6 - AUNT
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

7 - UNCLE
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

8 - MATERNAL GRANDMOTHER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

9 - MATERNAL GRANDFATHER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

10 - PATERNAL GRANDMOTHER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

11 - PATERNAL GRANDFATHER
- ☐ living
- ☐ deceased

Age at death: ____
Cause:_____

12 - OTHER

_____
_____

☐ adopted

_____allergies	_____ovarian cancer	_____cystic fibrosis	_____glaucoma	_____kidney stones	_____PKU
_____Alzheimer's Disease	_____uterine cancer	_____dementia	_____hearing loss	_____melanoma	_____seizures
_____anemia	_____lung cancer	_____depression	_____heart attack	_____memory loss	_____sickle cell anemia
_____aortic aneurysm	_____colon or rectal cancer	_____developed heart disease (pre age 65)	_____heart trouble	_____mental illness	_____smoking
_____asthma	_____skin cancer	_____diabetes (insulin injections)	_____high blood pressure	_____mental retardation	_____stillborn infant death
_____arthritis	_____prostate cancer	_____diabetes (no insulin)	_____high cholesterol	_____migraine	_____stroke
_____bipolar disorder	_____high cholesterol	_____down syndrome	_____overactive thyroid	_____nervous system tumors	_____violence/ domestic abuse
_____birth defects	_____chronic infections	_____emphysema	_____underactive thyroid	_____obesity	_____Von Willebrand disease
_____bleeding problems	_____clotting problems	_____epilepsy	_____infertility	_____osteoporosis	_____alcohol abuse
_____cancer (type not know)	_____colon polyps	_____fibromyalgia	_____iron storage disease	_____hip fracture	_____drug abuse
_____breast cancer		_____gallstones	_____kidney disease	_____osteoarthritis	
				_____Parkinson's	

SOCIAL HISTORY

- ☐ single
- ☐ married
- ☐ 2nd marriage
- ☐ 3rd marriage
- ☐ widowed
- ☐ divorced
- ☐ separated
- ☐ partner
- ☐ same sex partner
- ☐ married to same sex partner
- ☐ domestic partner

TOTAL NUMBER OF CHILDREN

living sons: ____
deceased sons: ____
living daughters: ____
deceased daughters: ____

WHO DO YOU LIVE WITH?
- ☐ spouse
- ☐ partner
- ☐ same sex partner
- ☐ family
- ☐ parents
- ☐ friend
- ☐ alone
- ☐ roommate
- ☐ other _____
_____

SEXUAL ACTIVITY (CHECK ALL THAT APPLY)
- ☐ never been sexually active
- ☐ currently sexually active
- ☐ previously sexually active
- ☐ with men
- ☐ with women
- ☐ vaginal sex
- ☐ anal sex
- ☐ oral sex
- ☐ satisfied
- ☐ unsatisfied
- ☐ never had an STI
- ☐ current/ previous STI
- ☐ never been tested for STIs, including HIV
- ☐ have been tested for STIs, including HIV

Submit via Email

HOW WOULD YOU DESCRIBE YOUR SUPPORT SYSTEM?
- ☐ good
- ☐ questionable
- ☐ poor
- ☐ inadequate
- ☐ no support system

EDUCATION
- ☐ post graduate
- ☐ college graduate
- ☐ some college
- ☐ high school grad
- ☐ some high school
- ☐ GED
- ☐ trade school
- ☐ full-time student
- ☐ part-time student

EMPLOYMENT STATUS
- ☐ full time
- ☐ part time
- ☐ retired
- ☐ disabled on disability
- ☐ disabled, not on disability
- ☐ stay at home parent
- ☐ student
- ☐ unemployed
- ☐ inmate
- ☐ parolee

Occupation:
_____

MILITARY SERVICE

☐ YES ☐ NO

If yes, how many years of service? ____
Service Status: _____

WHAT STRESSORS DO YOU HAVE?
- ☐ none
- ☐ financial
- ☐ marital
- ☐ family stressors
- ☐ emotional
- ☐ estranged from family
- ☐ health problems
- ☐ physical condition
- ☐ family situation
- ☐ living situation
- ☐ job situation
- ☐ sexual orientation