# New Patient Registration

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: Home: _____

_____ Mobile: _____

_____ Work: _____

Email address: _____

Insurance Carrier: _____

***With your permission, we would like a copy of your insurance card for your chart. Although Dr. Knowles does not accept insurance payments for services, the information is sometimes necessary for ordering tests and making referrals.***

Preferred Pharmacy - Local: _____

Mail Order *(if used)*: _____

Emergency Contact: _____

Phone: _____ Relationship to Patient: _____

Medications/Supplements You are Currently Taking:

| *Name* | *Strength/Dose* | *Frequency* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Allergies to Medications or Other Substances:

*Name* *Reaction*

_____

_____

_____

## Medical Problems/Diagnoses - *(circle all that apply)*:

| | | |
|---|---|---|
| High blood pressure | Pneumonia | Alcoholism |
| Heart disease | Sleep apnea | Drug abuse |
| Heart attack/MI | Neuropathy | Dementia/memory loss |
| Congestive Heart failure | Fibromyalgia | Parkinson's disease |
| Atrial fibrillation | Rheumatoid arthritis | Multiple sclerosis |
| Vascular disease | Osteoarthritis | Seizure |
| Aneurysm | Gout | Seasonal allergies |
| Stroke | Lupus | Chronic sinusitis |
| High cholesterol | Lyme disease | Glaucoma |
| Diabetes | GERD/Acid reflux | Macular degeneration |
| Thyroid disease | Ulcer | Kidney disease |
| Vitamin D deficiency | Diverticulitis | Kidney stones |
| Osteoporosis | Liver disease | Enlarged prostate |
| Blood clots | Crohn's disease | Erectile dysfunction |
| Bleeding disorder | Ulcerative colitis | Polycystic ovaries |
| Anemia | Chronic constipation/diarrhea | Chronic pain |
| Leukemia | Gallstones/gallbladder disease | ADHD |
| Cancer | Pancreatitis | Eczema |
| HIV/AIDS | Chronic headaches/migraine | Rosacea |
| Asthma | Anxiety/depression | Psoriasis |
| COPD/Emphysema | Bipolar disorder | Skin cancer |
| COVID-19 | Chronic insomnia | Herpes zoster (shingles) |

## Most recent colonoscopy:

## Most recent mammogram:

## Vaccine History

| | |
|---|---|
| COVID-19 | Date(s): |
| Influenza | Date of most recent: |
| Pneumococcal (pneumonia) | Date(s): |
| Hepatitis | Date(s): |
| Herpes zoster (shingles) | Date(s): |
| Tetanus | Date(s): |

Surgical History

*Name of Procedure* *Approximate Date*

_____

_____

_____

_____

_____

Social History

Occupation/Job: _____

Marital Status: _____ Number of children: _____

Name of Spouse: _____

Do you currently use tobacco products, smoke, or vape? *(please circle one)* Yes No

If yes, what? *(circle all that apply)* Cigarettes Cigars Marijuana Dip/chew Vape Other

How much per day? _____ How long? _____If quit, when? _____

Alcohol consumption *(please circle one)*: none occasional regular heavy

Substance/drug abuse *(circle all that apply)*: none marijuana meth heroin cocaine other

Family History

*Relationship* *Condition*

_____

_____

_____

_____

_____

_____

Previous Primary Care Provider: _____

City/State: _____ Phone: _____

Other Providers (Consultants or Specialists) Involved in Your Care:

*Name* *Specialty* *Location*

_____

_____

_____