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 (CHILD UNDER 12)

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

BRAIN OR NERVES? ☐YES ☐NO

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

BLOOD OR CANCER? ☐YES ☐NO

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

HORMONES/METABOLISM? ☐YES ☐NO

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

MENTAL STATE? ☐YES ☐NO

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

HAVE YOU EVER HAD ANY OF THESE INFECTIONS?

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

TETANUS STATUS

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

RISK FACTORS

☐passive smoke exposure

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 ☐3
☐1 ☐4

EXERCISE

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

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

OB/GYN (FEMALES ONLY)

First period at age: _____

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

SOCIAL HISTORY

WHO DO YOU LIVE WITH?

☐spouse
☐partner
☐same sex partner
☐family
☐parents
☐friend
☐alone
☐roommate
☐other _____
_____

HOW WOULD YOU DESCRIBE YOUR SUPPORT SYSTEM?

☐good
☐questionable
☐poor
☐inadequate
☐no support system

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

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