



## NEW PATIENT REGISTRATION AND HISTORY

*Please Complete ENTIRE Form and Return to Front Desk  
Settlement of Patient Financial Responsibility is Expected at Time of Service*

### **PATIENT INFORMATION:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex:  M  F  
Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

May we leave a message regarding your care (x-ray, lab results) on your phone:  Yes  No  
May we send electronic messages to your email address on file:  Yes  No  
Would you like to receive text reminders of upcoming appointments:  Yes  No

Parent or Legal Guardian name (if applicable): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address (if different): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

### **Acknowledgements:**

**HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgment Form (§164.520(a)):** I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been given an opportunity to review and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I further understand that this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested

**FINANCIAL AGREEMENT:** I understand that I am financially responsible and agree to pay all of the charges associated with my care. I understand that I am responsible for payment at the time the service is provided and, if required agree to enter into a separate financial contract.

**CONSENTS, DISCLOSURES AND ACKNOWLEDGMENTS:** I voluntarily consent to treatment for myself and/or my dependents. I acknowledge that I have been advised of my right to receive copies of any documents and records which Peak Performance Medical, LLC. has in its possession for myself and/or my dependent.

**RELEASE OF INFORMATION:** I authorize the facility to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization review, transfer, and follow-up purposes. I understand that a copy of this agreement may be used with the same effectiveness as an original.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_



## **MEDICAL HISTORY**

*All Information Obtained Will be Kept in Accordance With Applicable HIPAA Privacy Standards*

Name: (Last, First, Mi) \_\_\_\_\_  M  F D.O.B: \_\_\_\_\_

Marital Status:  Single  Partnered  Married  Separated  Divorced  Widowed

Previous/Referring Physician: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

### **PERSONAL HEALTH HISTORY**

**Childhood Illness:**  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

**Immunizations and Dates (if known):**

Tetanus \_\_\_\_\_  
 Hepatitis \_\_\_\_\_  
 Influenza \_\_\_\_\_

Pneumonia \_\_\_\_\_  
 Chickenpox \_\_\_\_\_  
 MMR \_\_\_\_\_ (measles, mumps, rubella)

**List any Medical Problems That Other Doctors Have Diagnosed:**

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Surgeries:**

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Other Hospitalizations:**

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Have You Ever had a Blood Transfusion?**  Yes  No **If so Appro'x Date of Last Transfusion:** \_\_\_\_\_

**Are you Allergic to any Medications? If so, Please List Allergic Reaction:**

Medication	Reaction
_____	_____
_____	_____
_____	_____

**Are you Allergic to Latex:**  Yes  No?

**Do you Have Any Other Allergies? If yes, Please explain:** \_\_\_\_\_  
 \_\_\_\_\_

**Please list any medications you are currently taking, along with dosage and frequency (including non-prescription medications, vitamins, herbs, or supplements.):**

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family History:**

	Age	Significant Health Problems		Age	Significant Health Problem
Father			Children		
Mother			<input type="checkbox"/> M <input type="checkbox"/> F		
Siblings			<input type="checkbox"/> M <input type="checkbox"/> F		
<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F		
<input type="checkbox"/> M <input type="checkbox"/> F			Grandmother (paternal)		
<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather (paternal)		
<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather (maternal)		
<input type="checkbox"/> M <input type="checkbox"/> F			Grandmother(maternal)		

**Mental Health:**

	YES	NO
1. Is Stress a Major Problem for You?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do You Feel Depressed?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do You Panic When Stressed?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do You Have Problems With Eating or Your Appetite?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do You Cry Frequently?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have You Ever Attempted Suicide?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have You Ever Seriously Thought About Hurting Yourself?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do You Have Trouble Sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have You Ever Been to a Counselor?	<input type="checkbox"/>	<input type="checkbox"/>

**Men Only:**

	YES	NO
1. Do You Usually Get Up to Urinate Through the Night? If Yes, How Many Times? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Do You feel Pain or Burning When Urinating?	<input type="checkbox"/>	<input type="checkbox"/>
3. Any Blood in Your Urine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do You Feel Burning Discharge From Penis?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the Force of your Urination Deceased?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have You Had Any Kidney, Bladder or Prostate Infections within the last 12 Months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do You Have Any Problems Emptying Your Bladder Completely?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any Difficulty with Erection or Ejaculation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Any Testicle Pain or Swelling?	<input type="checkbox"/>	<input type="checkbox"/>
10. Date of Last Prostate Exam _____ Rectal Exam _____		

**Women Only:**

	YES	NO
1. Age at Onset of Menstruation _____		
2. Date of Last Menstruation _____ Period Every _____ Days		
4. Heavy Periods, Irregularity, Spotting, pain or Discharge	<input type="checkbox"/>	<input type="checkbox"/>
5. Number of Pregnancies _____ Number of Live Births _____		
6. Are You Pregnant or Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have You Had a D&C, Hysterectomy or Cesarean?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any Urinary tract, Bladder or Kidney Infections Within the Last Year?	<input type="checkbox"/>	<input type="checkbox"/>
9. Any Blood in Your Urine?	<input type="checkbox"/>	<input type="checkbox"/>
10. Any Problem With Control of Urination?	<input type="checkbox"/>	<input type="checkbox"/>
11. Any Hot Flashes or Sweating at Night?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do You Have Menstrual Tension, Pain, Bloating, Irritability at the Time of Period?	<input type="checkbox"/>	<input type="checkbox"/>
13. Experienced Any Recent Breast Tenderness, Lumps or Nipple Discharge?	<input type="checkbox"/>	<input type="checkbox"/>
14. Date of Last Pap Exam _____ Rectal Exam _____	<input type="checkbox"/>	<input type="checkbox"/>

**Other Conditions/Discomforts** (please check and briefly explain any conditions/discomforts affecting the following)

<input type="checkbox"/> Skin _____ _____	<input type="checkbox"/> Bladder _____ _____
<input type="checkbox"/> Head/Neck _____ _____	<input type="checkbox"/> Chest / Heart _____ _____
<input type="checkbox"/> Ears _____ _____	<input type="checkbox"/> Circulation _____ _____
<input type="checkbox"/> Nose _____ _____	Recent Changes in:
<input type="checkbox"/> Throat _____ _____	<input type="checkbox"/> Weight _____
<input type="checkbox"/> Lungs _____ _____	<input type="checkbox"/> Energy Level _____
	<input type="checkbox"/> Ability to Sleep _____ _____

**Is There Anything Else About Your Physical and/or Mental Health That you Feel Our Providers Should Know?**

**If Yes, Please Explain:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The Information Contained in This Medical History Form, is to the Best of my Reasonable Information and Belief, True Correct and Accurate**

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_