Patient Registration Form

978-637-7643
hello@polarisfamilymed.com
www.polarisfamilymed.com

Patient Information

Name _____

Date Of Birth _____ Gender ◯ Male ◯ Female ◯ Other

Phone Number _____ Email _____

Can we leave a detailed voicemail at this number? ◯ Yes ◯ No

Address _____

_____

Emergency Contact Information

Name _____ Relationship _____

Phone Number _____ Email _____

Demographics

Race ◯ African American ◯ Native American ◯ White ◯ Hispanic ◯ Asian ◯ Other/Decline to Report

Ethnicity ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Other/Decline to Report

Language _____

Other Providers

Pharmacy _____

Eye Doctor _____

Dentist _____

Other _____

Immunizations

Date of last immunization

Influenza _____ Pneumonia _____

Tetanus/TDAP _____ Shingles _____

COVID _____ RSV _____

HPV _____ Other _____

Advanced Directives

Are you an organ donor? ◯ Yes ◯ No

Do you have any advanced directives, living will, power of attorney? ◯ Yes ◯ No

If so, does our office have a copy of these? ◯ Yes ◯ No

If not, would you like information regarding this? ◯ Yes ◯ No

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Medications

◯ See attached medication list

Please include all current medications including over the counter and supplements (use back of last page for additional medications)

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Allergies

◯ No known drug allergies

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

Environmental _____ Reaction _____

Food _____ Reaction _____

Female Patients

Last Period _____ Last Pap Smear _____

Last Mammogram _____ Last DEXA _____

Birth Control Method _____

OBGYN Provider Name _____

Obstetric History

Pregnancies _____ # Births _____

Surgical History

◯ No surgical history

Appendix _____ Historectomy _____

C-Section _____ Joint Surgery _____

Eye Surgery _____ Tonsils _____

Gallbladder _____ Wisdom Teeth _____

Heart Surgery _____ Other _____

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Social History

Are you employed? ◯ Full Time ◯ Part Time ◯ Retired ◯ Disabled ◯ Stay at Home ◯ Unemployed

What do you do for work? _____

Who lives in your home with you? _____

Do you have any pets?	◯ No	◯ Yes
Do you have carbon monoxide/smoke detectors?	◯ Yes	◯ No
Do you have any weapons in your home?	◯ No	◯ Yes
If so, is it safely stored?	◯ Yes	◯ No
Do you feel safe at home?	◯ Yes	◯ No
Do you feel safe in your relationships?	◯ Yes	◯ No
Have you been physically hurt by your partner?	◯ No	◯ Yes
Do you drink any alcoholic beverages?	◯ No	◯ Yes
Do you use drugs?	◯ No	◯ Yes
Do you smoke?	◯ No	◯ Yes
Do you drink caffiene (coffee, tea, soda, etc)?	◯ Yes	◯ No
Do you have any dietary restrictions?	◯ No	◯ Yes
Have you traveled out of the country recently?	◯ No	◯ No

What do you do for exercise? _____

Family History

◯ Adopted and family history unknown

Has anyone in your family been diagnosed with one of the following conditions? :
breast cancer, blood/clotting problems, colon cancer, diabetes, heart problems, high cholesterol, hypertension, lung cancer, ovarian cancer, prostate cancer, stomach disorders, stroke, other cancers, other conditions

Mother _____

Father _____

Brother _____

Sister _____

PGF _____

PGM _____

MGF _____

MGM _____

Other _____

Siblings ◯ Only child # Brothers _____ # Sisters _____

Children ◯ None # Sons _____ # Daughters _____

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Medical History

Have you ever been diagnosed with any of the following?

Heart Problems	**N / Y**
High Blood Pressure/Hypertension	N / Y
High Cholesterol	N / Y
Heart Attack	N / Y
Heart Murmur	N / Y
Sleep Apnea	N / Y

Breathing Problems/Lung Disorders	**N / Y**
Asthma	N / Y
COPD	N / Y

Kidney Problems/Renal Disorders	**N / Y**
Kidney Stone	N / Y
Kidney Infections	N / Y

Infectious Diseases	**N / Y**
Chicken Pox/Shingles	N / Y
Sexually Transmitted Diseases	N / Y

Stomach Problems/GI Disorders	**N / Y**
Diverticulitis	N / Y
IBS/IBD	N / Y
GERD/Reflux/Heartburn	N / Y
Hepatitis	N / Y
Hernia	N / Y

Urinary Problems	**N / Y**
Recurrent UTI	N / Y
Overactive Bladder	N / Y
BPH	N / Y

Endocrinologic Problems	**N / Y**
PCOS	N / Y
Thyroid Problems	N / Y
Diabetes	N / Y
Pre-Diabetes	N / Y
Obesity	N / Y

Skin Problems	**N / Y**
Acne	N / Y
Skin Lesions/Moles	N / Y
Hair Loss	N / Y
Eczema	N / Y

Neurologic Problems	**N / Y**
Migraine	N / Y
Concussion	N / Y
Seizure	N / Y
Stroke	N / Y
Neuropathy	N / Y

Hematologic Disorders	**N / Y**
Anemia	N / Y
Blood Clot (DVT or PE)	N / Y
Bleeding Disorder	N / Y
Cancer	N / Y
Vitamin Deficiency	N / Y

ENT Issues	**N / Y**
Seasonal/Environmental Allergies	N / Y
Ear Problems	N / Y
Hearing Problems	N / Y
Eye Problems	N / Y
Vision Problems	N / Y
Dentures	N / Y

Musculoskeletal Problems	**N / Y**
Joint Problems	N / Y
Arthritis	N / Y
Chronic Pain	N / Y

Other Diagnosis	**N / Y**
Anxiety	N / Y
Depression	N / Y
ADHD	N / Y
Eating Disorder	N / Y
Alcohol/Drug Use	N / Y
Other Mental Health Diagnosis	N / Y
Congenital Problems/Defects	N / Y
Autoimmune Disorders	N / Y
Arthritis	N / Y
Chronic Pain	N / Y
Other	N / Y

Additional Information

Do you have any specific concerns or other pertinent medical information you'd like to share with us?

_____

_____

_____

_____
Patient's Signature

_____
Date

Reviewed by _____