PATIENT REGISTRATION

Five (5) Pages and Please Print Clearly

Patient's Name: _____ **Date of Birth:** _____ **Gender:** _____
(First) (M.I.) (Last)

Age: _____ **Social Security #:** _____

Address: _____ **Home Ph:** _____ ❑ Prefer?

City: _____ State: _____ Zip: _____ **Cell Ph:** _____ ❑ Prefer?

Primary Language?: _____ **Occupation:** _____

Race: _____ ❑ Decline? **Work Ph:** _____ ❑ Prefer?

Ethnicity (Hispanic Y/N): _____ ❑ Decline?

Emergency Contact: _____ Relationship?: _____ Phone: _____

How were you referred to the Jho Institute? (Check all that apply)

❑ Referring Physician (See Below) ❑ Friend/Family ❑ www.drjho.com ❑ Other: _____

PHYSICIAN INFORMATION

- If referred by a specific physician, please list below:

Referring Physician: _____ ❑ MD ❑ DO ❑ Other: _____

Address: _____ Suite: _____ City: _____ State: _____ Zip: _____

Phone #: _____ **Fax #:** _____ **Physician Specialty:** _____

- Please list any other physicians to whom you wish your records be sent:

Family Physician: _____ ❑ MD ❑ DO ❑ Other: _____

Address: _____ Suite: _____ City: _____ State: _____ Zip: _____

Phone #: _____ **Fax #:** _____ **Physician Specialty:** _____

Other Physician: _____ ❑ MD ❑ DO ❑ Other: _____

Address: _____ Suite: _____ City: _____ State: _____ Zip: _____

Phone #: _____ **Fax #:** _____ **Physician Specialty:** _____

RELEASE OF INFORMATION: I authorize the release of this medical record, any related studies, and other information to my family physician (s), the doctor to whom I am referred, my legal counsel, and to the applicable third-party payor.

Patient or Authorized Person: _____ **Date:** _____

INSURANCE INFORMATION

- Please list all insurance(s) applicable for this visit:

Primary Insurance: _____ **Policy #:** _____

Subscriber Name: _____ Sub DOB: _____ **Group #:** _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ **Policy #:** _____

Subscriber Name: _____ Sub DOB: _____ **Group #:** _____

Ins. Address: _____ City: _____ State _____ Zip: _____

- **Is today's visit related to an accident? ❑ Y ❑ N If Yes,** ❑ Work Related ❑ Auto ❑ Other: _____

Work/Auto Insurance: _____ **Policy/Claim #:** _____

Date of Accident: _____ **State:** _____ **Injured Body Part(s):** _____

Employer/Policy Holder: _____ **Contact Person:** _____ **Ph #:** _____

Employer/Auto Ins. Address: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits per appropriate assignment(s) above to the physician or organization rendering services, not to exceed the balance due of any aforementioned provider's regular charges for this period of service.

Patient or Authorized Person: _____ **Date:** _____

PATIENT MEDICAL HISTORY

Please Complete Fully and Print Clearly

Height: _____ Weight: _____ Date Of Onset: _____

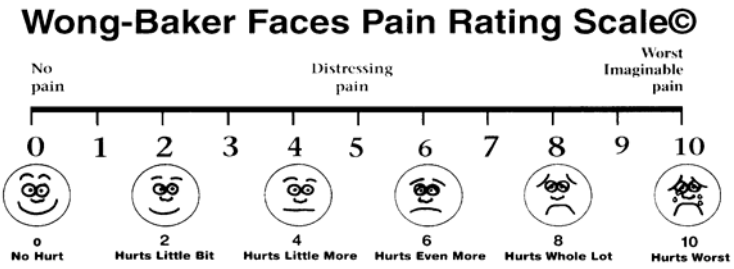
Reason for Today's Visit: _____

Describe Present Condition: _____

_____

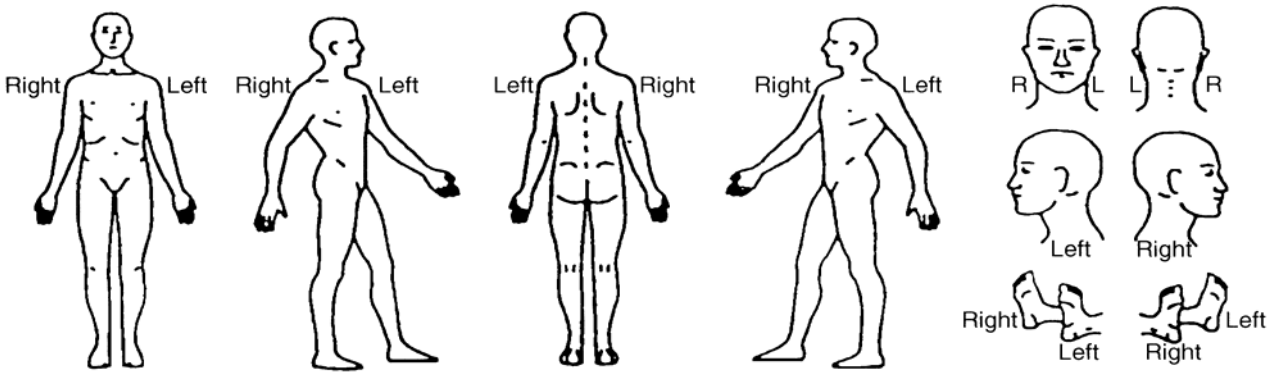
_____

PLEASE COMPLETE THE PAIN SCALE AND BODY PICTURE BELOW



Please mark the areas on your body where you feel the following sensations, using the symbol below:

★ NUMBNESS
• PINS/NEEDLES
X BURNING
/ STABBING



Is your pain: ❑ SHARP; ❑ DULL; ❑ ACHING; ❑ STABBING; ❑ BURNING; ❑ TINGLING; ❑ NUMB

Have you had any loss of bowel/bladder control? ❑ N ❑ Y – Describe _____

When do you have pain? ❑ CONSTANTLY; ❑ DAILY; ❑ WEEKLY; ❑ MONTHLY; ❑ OTHER _____

What makes your pain worse?

_____

_____

What makes your pain better?

_____

_____

Patient Name: _____ **Date:** _____

PATIENT MEDICAL HISTORY

MEDICAL HISTORY:

- **Patient Medical History:**

Diabetes	❑	Y	❑	N
Hypertension	❑	Y	❑	N
Heart Disease	❑	Y	❑	N
Abnormal Bleeding	❑	Y	❑	N
Acute Infections	❑	Y	❑	N
Arthritis/Gout	❑	Y	❑	N
Stomach Problems	❑	Y	❑	N
Thyroid Disease	❑	Y	❑	N
Lung Disease or TB	❑	Y	❑	N
Cancer	❑	Y	❑	N
Stroke	❑	Y	❑	N
Convulsions	❑	Y	❑	N
Nervous Disorder	❑	Y	❑	N
Hereditary Defects	❑	Y	❑	N
Other:				

- **Patient Surgical History:**

List previous hospitalizations / surgeries / serious injuries:

Procedure	**When?**

- **Patient Social History:**

Marital Status: ❑ - Single ❑ - Married ❑ - Partner ❑ - Separated ❑ - Divorced ❑ - Widowed

Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Use of Tobacco: ❑ Never ❑ Previously, but quit: _____ Months / Yrs. ago Current PPD: _____

Are you on a special diet? ❑ No ❑ Yes What Type? _____

Is there a possibility that you are pregnant? ❑ Yes ❑ No

Have you had a recent cold, flu, infection (i.e.: dental, urinary)? ❑ No ❑ Yes _____

Are you taking aspirin? ❑ No ❑ Yes (Tablets / Dose / Day: _____)

- **Do you have an Advanced Directive / Living Will?** ❑ Yes ❑ No

- **Family Medical History:**

	Age	**Disease (s):**	**If Deceased, Cause of Death**
Father			
Mother			
Siblings			
Grandp. (M)			
Grandp. (P)			
Children			

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS: Please Indicate any Personal History Below

- CONSTITUTIONAL SYMPTOMS
  - Good general health lately ❑ Yes ❑ No
  - Recent weight change ❑ Yes ❑ No
  - Fever ❑ Yes ❑ No
  - Fatigue ❑ Yes ❑ No
  - Headaches ❑ Yes ❑ No
- EYES
  - Eye disease or injury ❑ Yes ❑ No
  - Wear glasses/contact lenses ❑ Yes ❑ No
  - Blurred or double vision ❑ Yes ❑ No
  - Glaucoma ❑ Yes ❑ No
- EARS/NOSE/MOUTH/THROAT
  - Hearing loss or ringing ❑ Yes ❑ No
  - Earache or drainage ❑ Yes ❑ No
  - Chronic sinus problems or rhinitis ❑ Yes ❑ No
  - Nose bleeds ❑ Yes ❑ No
  - Mouth sores ❑ Yes ❑ No
  - Bleeding gums ❑ Yes ❑ No
  - Bad teeth or bad taste ❑ Yes ❑ No
  - Sore throat or voice change ❑ Yes ❑ No
  - Swollen glands in neck ❑ Yes ❑ No
- CARDIOVASCULAR
  - Heart trouble ❑ Yes ❑ No
  - Chest pain or angina pectoris ❑ Yes ❑ No
  - Palpitations ❑ Yes ❑ No
  - Shortness of breath with walking/lying flat ❑ Yes ❑ No
  - Swelling of feet, ankles, or hands ❑ Yes ❑ No
- RESPIRATORY
  - Chronic or frequent cough ❑ Yes ❑ No
  - Spitting up blood ❑ Yes ❑ No
  - Shortness of breath ❑ Yes ❑ No
  - Asthma or wheezing ❑ Yes ❑ No
- GASTROINTESTINAL
  - Loss of appetite ❑ Yes ❑ No
  - Change in bowel movements ❑ Yes ❑ No
  - Nausea or vomiting ❑ Yes ❑ No
  - Frequent diarrhea ❑ Yes ❑ No
  - Painful bowel movements or constipation ❑ Yes ❑ No
  - Rectal bleeding or blood in stool ❑ Yes ❑ No
  - Peptic ulcer ❑ Yes ❑ No
- GENITOURINARY
  - Frequent urination ❑ Yes ❑ No
  - Burning or painful urination ❑ Yes ❑ No
  - Blood in urine ❑ Yes ❑ No
  - Change in force of stream when urinating ❑ Yes ❑ No
  - Incontinence or dribbling ❑ Yes ❑ No
  - Kidney stones ❑ Yes ❑ No
  - Sexual difficulty ❑ Yes ❑ No
  - Male-testicular pain ❑ Yes ❑ No
  - Female-pain with periods ❑ Yes ❑ No
  - Female-irregular periods ❑ Yes ❑ No
  - Female-vaginal discharge ❑ Yes ❑ No
- MUSCOLOSKELETAL
  - Joint pain ❑ Yes ❑ No
  - Joint stiffness or swelling ❑ Yes ❑ No
  - Weakness of muscles or joints ❑ Yes ❑ No
  - Muscle pain or cramps ❑ Yes ❑ No
  - Back pain ❑ Yes ❑ No
  - Cold extremities ❑ Yes ❑ No
  - Difficulty in walking ❑ Yes ❑ No
- INTEGUMENTARY (skin, breasts)
  - Rash or itching ❑ Yes ❑ No
  - Change in skin color ❑ Yes ❑ No
  - Change in hair or nails ❑ Yes ❑ No
  - Varicose veins ❑ Yes ❑ No
  - Breast pain ❑ Yes ❑ No
  - Breast lump ❑ Yes ❑ No
  - Breast discharge ❑ Yes ❑ No
- NEUROLOGICAL
  - Frequent or recurring headaches ❑ Yes ❑ No
  - Light headed or dizzy ❑ Yes ❑ No
  - Convulsions or seizures ❑ Yes ❑ No
  - Numbness or tingling sensations ❑ Yes ❑ No
  - Tremors ❑ Yes ❑ No
  - Paralysis ❑ Yes ❑ No
  - Stroke ❑ Yes ❑ No
  - Head Injury ❑ Yes ❑ No
- PSYCHIATRIC
  - Memory loss or confusion ❑ Yes ❑ No
  - Nervousness ❑ Yes ❑ No
  - Depression ❑ Yes ❑ No
  - Insomnia ❑ Yes ❑ No
- ENDOCRINE
  - Glandular or hormone problem ❑ Yes ❑ No
  - Thyroid disease ❑ Yes ❑ No
  - Diabetes(insulin or non-insulin–circle one) ❑ Yes ❑ No
  - Excessive thirst or urination ❑ Yes ❑ No
  - Heat or cold intolerance ❑ Yes ❑ No
  - Skin becoming drier ❑ Yes ❑ No
  - Change in hat or glove size ❑ Yes ❑ No
- HEMATOLOGICAL/LYMPHATIC
  - Slow to heal after cuts ❑ Yes ❑ No
  - Bleeding or bruising tendency ❑ Yes ❑ No
  - Anemia ❑ Yes ❑ No
  - Phlebitis ❑ Yes ❑ No
  - Past transfusions ❑ Yes ❑ No
  - Enlarged glands ❑ Yes ❑ No
- ALLERGIC/IMMUNOLOGIC
  - History of skin reaction or other adverse reactions to:
  - Penicillin or other antibiotics ❑ Yes ❑ No
  - Morphine, Demerol, or other narcotics ❑ Yes ❑ No
  - Novocain or other anesthetics ❑ Yes ❑ No
  - Aspirin or other pain remedies ❑ Yes ❑ No
  - Tetanus antitoxin or other serums ❑ Yes ❑ No
  - Iodine, methylate or other antiseptic ❑ Yes ❑ No

Patient Name: _____ Date: _____

MEDICATION FORM

Please list all medications including vitamins and herbs (Please also feel free to attach a pre-prepared list)

Name of Medication	Dosage	How Many per Dose	Times per Day	Last Time You Took	How Long on Med.

ALLERGY HISTORY

Note: Please include any known allergies or reaction to MRI or CT imaging/contrast dyes

List all Allergies _____ _____ _____ _____ _____

And Your Reaction to Them _____ _____ _____ _____ _____

Patient Name: _____ Date: _____

(DRS USE ONLY) All systems and history was reviewed with the patient _____

- FIRST CONSULTATION/VISIT DATE OF VISIT: _____

SUBSEQUENT VISITS

- ❑ Change ❑ No Change DATE OF VISIT: _____

NOTES: _____

- ❑ Change ❑ No Change DATE OF VISIT: _____

NOTES: _____

- ❑ Change ❑ No Change DATE OF VISIT: _____

NOTES: _____