Quality Medical Fitness
Cardiopulmonary Rehab

389 Fort Salonga Road
Northport, NY 11768
Phone: 631-686-6658
Fax: 631-651-8959

REGISTRATION FORM

PATIENT INFORMATION

DATE:

Last Name:	First:	Middle:	☐ Mr. ☐ Ms. ☐ Mrs. ☐ ____	Marital Status:

Is this your legal name? ☐ Yes ☐No	If not, what is your legal name?	(Former name):	Birth Date:	Age:	Sex: ☐Male ☐Female

Street Address:	Social Security No.:	Home Phone: ( ) Mobile Phone: ( )

City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone No.:

Referred By:

☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Contact Phone No.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Is this patient covered by insurance? ☐ Yes ☐ No

Primary Insurance:

Subscriber's Name:	Social Security No.:	Birth Date:	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:

Subscriber's Name:	Group No.:	Policy No.:

Patient's relationship to subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other

SIGNATURES

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance or if the insurance denies the payment. I also authorize Quality Medical Fitness or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	*Date:*

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Name: _____

Date of Birth: _____

What brings you in today? _____

_____

What do you prefer to be called (nickname)? _____

Please list all your medical conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

What surgical or medical procedures have you had in the past?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please tell us about medical conditions in your family including cancer, diabetes, heart disease, etc., and at what age they developed the disease:

Mother: _____ Age: _____
Father: _____ Age: _____
Siblings: _____ Age: _____
Others: _____ Age: _____

What medications, herbs, and vitamins / supplements are you currently taking? Remember to include over-the-counter medicines. Please include the doses and how often you take each one.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Pharmacy Name _____

Address _____

Phone No. _____

Allergies? ☐ Yes ☐ No **If "Yes," reactions?** _____

Social History:

Relationship Status: ☐ Married / Partner ☐ Single ☐ Divorced ☐ Widowed

Have you ever been pregnant: ☐ Yes ☐ No How many times? _____

Do you have children: ☐ Yes ☐ No How many? _____

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Who lives with you at home? _____

Do you feel safe at home and in your current relationship? ☐ Yes ☐ No

What is your occupation? _____

What (if any) physical activity / exercise do you engage in and how often? _____

_____

How would you describe your dietary intake? _____

_____

Do you drink alcohol? Yes _____ No _____ If yes, how much alcohol do you drink? _____ per day _____ per week _____ per month

Do you smoke? ☐ Now ☐ Past ☐ Never

If so, how many per day and for how long? _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

How often have you noticed the following emotions over the last two weeks: (check the answer that best describes how you feel)

Little interest in doing things	☐None	☐Several days	☐More than half the days	☐Nearly everyday
Feeling down or depressed	☐None	☐Several days	☐More than half the days	☐Nearly everyday

Review of systems: Please check if you are currently having any of the following symptoms.

Constitutional
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
- ☐ Fatigue
- ☐ Excessive sleepiness/ insomnia

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Eye dryness

Respiratory
- ☐ Cough
- ☐ Trouble breathing
- ☐ Frequent illness

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Heartburn

Skin
- ☐ Rash
- ☐ Nail changes
- ☐ Mole Changes

Endocrinologic
- ☐ Excessive thirst
- ☐ Hot or cold always
- ☐ Excessive urination

Hematologic
- ☐ Abnormal bleeding/bruising
- ☐ Lumps or swelling

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Ear / Nose / Throat

- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Hoarseness
- ☐ Trouble swallowing
- ☐ Sneezing frequently
- ☐ Runny / Stuffy nose
- ☐ Snoring
- ☐ Choking / gasping during sleep

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations

Genitourinary

- ☐ Leaking urine
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Heavy vaginal bleeding

Musculoskeletal

- ☐ Muscle pain or joint pain
- ☐ Muscle twitching / Cramping
- ☐ Joint Pain / Stiffness
- ☐ Joint swelling
- ☐ Trouble walking
- ☐ Falls / Fear of falling
- ☐ Back Pain

Psychiatric

- ☐ Anxiety
- ☐ Sad or depressed
- ☐ Trouble sleeping
- ☐ Memory problem
- ☐ Overwhelming
- ☐ Panic attacks

Neurologic

- ☐ Numbness / tingling
- ☐ Tremors
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory loss

Health Maintenance / Prevention

Please specify if and when you received the following services.

All patients:

- ☐ Influenza (flu) vaccine Date: _____
- ☐ Tetanus vaccine Date: _____
- ☐ Pertussis vaccine Date: _____
- ☐ Hepatitis A vaccine Date: _____
- ☐ Hepatitis B vaccine Date: _____
- ☐ Varicella vaccine Date: _____
- ☐ HIV test Date: _____
- ☐ Last dental exam Date: _____
- ☐ Last eye exam

Over 50:

- ☐ Pneumonia vaccine Date: _____
- ☐ Zostavax vaccine Date: _____
- ☐ Pertusis vaccine Date: _____
- ☐ Bone density scan Date: _____
- ☐ Blood in stool cards Date: _____
- ☐ Colonoscopy Date: _____

Women Only:

All:

- ☐ Pap smear Date: _____

Under 27:

- ☐ HPV / Gardasil vaccine Date: _____
- ☐ Chlamydia (urine test) Date: _____

Over 40:

- ☐ Mammogram Date: _____

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Men Only:

Under 27:

☐ HPV / Gardasil Vaccine Date: _____

Over 40:

☐ Abdominal ultrasound Date: _____

☐ PSA test Date: _____

Do you currently see any other physicians?

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Are you up to date on:

Tdap (tetanus, pertussis / whooping cough) Date: _____

HPV (Gardasil) Date: _____

Influenza (flu shot) Date: _____

Pneumonia-23 Date: _____

Pneumonia-13 Date: _____

Shingles (Zostavax) Date: _____

Are you up to date on the following:

Colonoscopy (colon cancer screening) Date: _____

Bone Density (osteoporosis screen) Date: _____

Mammogram (breast cancer screen) Date: _____

Pap smear (cervical cancer screen) Date: _____

Prostate cancer screen Date: _____

Privacy Officer
Quality Medical Fitness

Acknowledgment

By signing below, I acknowledge that I have been provided a copy of the Practice's Notice of Privacy Practices (the "Notice") and have therefore been advised of how health information about me may be used and disclosed by the Practice and how I may obtain access to an control this information. I also acknowledge that the practice may use and disclose my health information to treat me and arrange for my medical care, to seek, and receive payment for services given to me, and for the business operations of the practice, its staff.

_____ _____

Signature of patient or
Patient's representative

Date

_____

PRINT NAME