

Adult Medicine & Pain Management

1 Pinnacle Place, Ste. 203, Albany, NY 12203
Phone: 518-438-4700, Fax: 518-438-3190

Patient's Registration & Medical History

Please assist us by providing the following information. All information is confidential.
Please fill in the blanks and check the appropriate answers.

Date Completed: _____

Patient Name	Date of Birth	Age	Sex	Occupation
Social Security #	Employer's Name			
Home Address	City		State	Zip
Home Phone Number	Work Phone Number	Spouse Name		
Notify In Case of Emergency				
Name	Relationship			
Address	City		State	Zip
Home Phone Number	Work Phone Number			
Nearest Relative (Not Living With You)				
Home Phone Number	Work Phone Number			
Financial Information: Person Responsible For Fees				
Name	Phone Number			
Address	City		State	Zip
Insurance Company	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SS#		
Insurance ID #				
Secondary Insurance	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SS#		
Were You injured On The Job?	YES	NO	Have You Informed Your Employer?	YES NO
Date of Original Injury				
Worker's Compensation Carrier name	Address			
WCB Number	Case Worker's Name			
No Fault Insurance Info				

Please continue to fill out your Medical Self-History on the reverse side of this form

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History

Name				Doctor Notes <i>Please Do Not Write In This Area</i>			
Presenting Problem:							
ILLNESS / INJURY: Please Check If You Have Ever Had:							
YES	NO		YES	NO			
		High Blood Pressure			Kidney Stones		
		Diabetes			Abdominal Bleeding / Ulcers		
		Prolonged Bleeding			Thyroid Problem		
		Heart Attack / Chest Pain			Shortness of Breath		
		History of Heart Murmur			Lung Problems / Asthma		
		Stroke			Accidents / Broken Bones (list)		
		Hepatitis			Head Aches		
		Gallstones			Low Back Pain		
		Cancer			Drug Addiction		
OPERATIONS: List Names And Dates of All Operations You Have Had:						NONE	
Year	Name of Operation		Type of Anesthetic (If Known)		Complications		
Are You On Blood Thinners?							
FEMALES ONLY: Are You Pregnant?							
DRUGS: Please List All Drugs You Take And Their Doses:						NONE	
Drug		Dossage		Drug		Dossage	
ALLERGIES: Please List Type and Reaction:						NONE	
Do You Now Use Tobacco? YES NO				Day # Years ___ / ___			
Have You Ever Used Tobacco? YES NO				Years Quit ___			
Do You Drink Alcohol? YES NO				Day # Years ___ / ___ Type:			
Have You Ever Used Alcohol? YES NO				Years Quit ___ / ___			
PAIN INTENSITY Score Now (0-10)				PAIN LOCATION:			

