

Kurt W. Rathjen, M. D.

Patient Registration Form

DATE: _____

PATIENT INFORMATION

Patient's Name: _____ Sex: **M** **F** Marital Status: _____

First M Last
SS# _____ DOB _____ Age _____

Home Address: _____

City State Zip
Home Phone: (____) _____ Work Phone: (____) _____ Fax: (____) _____

Cell Phone: (____) _____ E-Mail: _____

Employed: **Full** **Part-time** Name of Employer: _____

Student: **Full** **Part-time** Name of School: _____

PARENTAL INFORMATION FOR MINORS (for patients under the age of 18)

Mother's Name: _____ Father's Name: _____

Mother's Date of Birth: _____ SS# _____ Father's Date of Birth: _____ SS# _____

FAMILY PHYSICIAN

Name: _____ Phone No.: _____

Address: _____
City State Zip

WHO SENT YOU TO OUR OFFICE

Name: _____ Phone No.: _____

Address: _____
City State Zip

EMERGENCY CONTACT- Name of relative or friend not living at your address to contact in case of emergency:

Name: _____ Phone No.: _____

Address: _____
City State Zip

PAST MEDICAL HISTORY - Please circle any current or past illnesses

Congestive heart failure	Renal Dialysis	High Blood Pressure	Heart Attack	Osteoporosis
Bleeding Disorder	Gastric Ulcer	Gastric Reflux	Seizures	Blood Clots (DVT)
Rheumatoid Arthritis	Hepatitis	Glaucoma	Asthma	Depression
Osteo Arthritis	Stroke	Gout	Lupus	HIV
Diabetes	Pulmonary Embolus	Sleep Apnea	Cancer (specify) _____	
Other _____				

PAST SURGICAL HISTORY - Please circle all that apply

Heart	Kidney	Liver	Appendectomy	Tonsils	Hysterectomy	Prostate
Bladder suspension	Hernia	Cataracts	Gallbladder	Coronary Bypass #of X's _____		
Back surgery	Neck surgery	Fracture Repair (specify site) _____				
Total Hip or Partial Hip Replacement: R L	Total Knee Replacement: R L	Knee Scope: R L				
Other: _____						

FAMILY HISTORY - Please circle all that apply or fill in blanks

Father: Age if living _____ Deceased at age _____ Mother: Age if living _____ Deceased at age _____

Number of Sisters: _____ Number of Brothers _____ Number of Children _____

Is there a family history of: (Please circle **Yes** or **No**)

Diabetes Yes No	High Blood Pressure Yes No	Sudden Unexplained Death Yes No
Asthma Yes No	Epilepsy Yes No	Heart Attack Yes No
Arthritis Yes No	Cancer Yes No	Other: _____

SOCIAL HISTORY - Please circle or fill in blanks

SINGLE MARRIED WIDOW / WIDOWER DIVORCED

Occupation: _____ Highest level of Education completed: _____

Alcohol: Number of drinks per week _____ () I never drink alcohol

Smoking: Number of Packs per day _____ for _____ years () I never smoked

Quit smoking on or about _____ Smoked # packs/day _____ for _____ years

Illicit Drug Use: _____

REVIEW OF SYSTEMS: (Please mark all that have occurred in the past year)**CONSTITUTIONAL**

Fever

Chills

Night sweats

Frequent Fatigue

Unexpected Weight loss

Weight gain

Frequent infections

EYE & VISION

Change in vision

Eye pain / redness

Double vision

Glasses / Contacts

Freq. Eye watering

Color blindness

Dry eyes

EARS & HEARING

Loss of hearing

Ear drainage

Ringing noises

Ear Pain

Hearing aids

Dizziness

Frequent itching

NOSE & THROAT

Hoarseness / dry throat

Difficulty Swallowing

Nosebleeds

Blocked Passages

Change in smell / taste

Removable teeth – partials

Dentures

CARDIOVASCULAR

Chest pain

Ankle swelling

Heart palpitations

Varicose veins

Irregular rhythm

Heart murmur

RESPIRATORY

Shortness of breath

Coughing up blood

Wheezing

Pain with breathing

Short of breath-
with little exercise

GASTROINTESTINAL

Bowel incontinence

Freq. Constipation

Freq. Diarrhea

Loss of Appetite

Hemorrhoids

Black tarry stools

GENITOURINARY

Bladder incontinence

Blood in urine

Difficulty urinating

Frequent urination

Freq. nighttime urination

Freq. urinary infections

MUSCULOSKELETAL

Joint pain & stiffness

Deformities

Muscle weakness

Muscle wasting

Spasms / Cramping

Limited range of motion

Low Back Pain

Lower Extremity Numbness/
Tingling

Sharp/Shooting Pains Down
Legs

NEUROLOGIC

Change in memory

Seizures

Tremors

Freq. Headaches

Paralysis

Balance Problems

ENDOCRINE

Temp. intolerance

Excessive Thirst

Hot Flashes

Low sex drive

Sexual dysfunction

PSYCHIATRIC

Depression

Difficulty sleeping

Nightmares

Bi-polar syndrome

**HEMATOLOGIC/
LYMPHATIC**

Bruise Easily

Abnormal Bleeding

Axilla / groin tenderness

Tender nodes, lumps

Transfusions

SKIN & BREAST

Rash

Tattoos

Ulcers / Open wounds

Hair / Nail Changes

Breast masses / tenderness

Keloid scar tendency

**ALLERGIC/
IMMUNOLOGIC**

Receiving allergy shots

Environmental Allergies

Problems with immunizations

Prolonged healing tendency

Lactose intolerance or other foods

To my knowledge the above information is correct. I give my consent for treatment for this illness or injury described herein and I understand that I am financially responsible to Kurt W. Rathjen, M.D. for all charges not covered by any and all insurances. Payment is expected at the time services are rendered. I understand that both parents of a minor patient may be asked to sign a statement of financial responsibility. **I authorize payment directly to Kurt W. Rathjen, M.D. of any insurance policy benefits payable to me, and I hereby assign all such policy benefits to Kurt W. Rathjen, M.D.**

PATIENT'S SIGNATURE

DATE

SIGNATURE OF ADDITIONAL RESPONSIBLE PARTY

DATE