Corinna Mosher, M.D. A Medical Corporation
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(805) 496-8522
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Patient Registration:

Last Name:_____ First Name:_____ MI:____

Address:_____ City:_____Zip Code_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Sex (M / F):_____ Marital Status: S M D W

Social Security #:_____ Driver's License #:_____

Emergency Contact Name:_____ Phone:_____

Relationship to Patient:_____

Employer:_____ City:_____Phone:_____

Who Referred You?_____

Insurance Information:

Primary Insurance Company:_____

Address:_____

Subscriber Name:_____ Relation to Insured:_____DOB___/___/___

ID#:_____ Group #:_____

Secondary Insurance Company:_____

Address:_____

Subscriber Name:_____ Relation to Insured:_____DOB___/___/___

ID#:_____ Group#:_____

I, THE UNDERSIGNED, AUTHORIZE PAYMENT BY THE ABOVE NOTED INSURANCE COMPANY(S) BE MADE DIRECTED TO CORINNA R. MOSHER, MD A MEDICAL CORPORATION FOR ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY SAID INSURANCE. INCLUDING DEDUCTIBLE AND COPAYMENTS. I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I FURTHER AGREE IN THE EVENT OF NONPAYMENT OF ANY AMOUNTS DUE BY ME, TO BEAR THE COST OF COLLECTION, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

Signature:_____ Date:_____

Health Questionnaire

What is the reason for your visit?_____
_____
_____
_____
_____

When was your last physical exam?_____

Past Medical History

Please list past medical problems: (Such as an illness, operation, or hospital stay)

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____
5. _____ Date:_____
6. _____ Date:_____
7. _____ Date:_____

Please list your current medications: (such as prescriptions, herbal supplements, & over the counter meds)

	Medicine	Dosage	How often (such as daily, twice daily, etc.)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Do you have any allergies to medications? Yes No

Medicine	Reaction (rash, shortness of breath, etc.)	Date or Age
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

When was your last papsmear? _____ Have you had an abnormal papsmear? _____

When was your last mammogram? _____ Have you had an abnormal mammogram? _____
Have you had a breast biopsy? _____

Number of pregnancies: ___ Number of births: _____ Miscarriages/Abortions: ____

What was your age during your first pregnancy: _____ Last menstrual period: _____

Average days of your period: ____ Age at menopause:____ Age of first period: _____

Have you ever used hormone replacement therapy? _____

When was your last bone density test?____ What were the results? _____

Have you been screened for colon cancer? (Flexible Sigmoidoscopy or Colonoscopy)_____
When was the test and what were the results?_____

When was your last prostate exam or PSA test?_____ Any abnormal result? _____

When was your last cholesterol test? _____Results? _____

When was your last EKG or cardiac test? _____ Results? _____

When was your last Tetanus Vaccine: _____ Influenza Vaccine: _____

Pneumonia Vaccine:_____ Hepatitis B series: _____

Hepatitis A series: _____

Family History

Please list all genetically related family members:

Relative	Age	Living/Deceased	Major Medical Illness/Cause of Death
1. Mother	_____	L / D	_____
2. Father	_____	L / D	_____
3. Brother/Sister	_____	L / D	_____
4. Brother/Sister	_____	L / D	_____
5. Brother/Sister	_____	L / D	_____
6. Brother/Sister	_____	L / D	_____
7. Brother/Sister	_____	L / D	_____

8. Father's Mother _____ L / D_____
9. Father's Father _____ L / D_____
10. Mother's Mother_____ L / D_____
11. Mother's Father _____ L / D_____

Social History

Please list the name, age, sex, and any major medical illness of your children:

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

What is your occupation?_____

What is your religion?_____

Have you ever smoked cigarettes? Yes No

How many packs per a day?
_____

Have you quit, if so when?_____

How many total years did you smoke?_____

How much alcohol do you typically drink?_____

What type of alcohol do you drink? Beer Wine Liquor

Has anyone ever urged you to quit drinking or to get counseling to quit? Yes No

Do you use any other drugs? (marijuana, cocaine, heroin, ecstasy, GHB, codeine, valium, speed, glue, etc.)

No Yes (please list):_____

Do you take a calcium supplement?_____

Do you always wear a seatbelt? Yes No

Do you have a gun at home? Yes No

How many days per a week do you exercise at least 30 minutes?
_____

Do you feel safe at home? Yes No

Review of Systems (Please circle any symptoms you have experienced in the past six months)

1. **General**: Fevers, Chills, Night sweats, Fatigue, Weight loss, Weight gain
2. **Head**: Dizziness, Headaches (frequent or unusual), Head injury
3. **Eyes**: Change in vision, Double vision, Eye Pain, Redness, Excessive tearing, Glaucoma
4. **Ears**: Ringing, Hearing loss, Hearing aid, Discharge, Pain, Bleeding
5. **Nose**: Nosebleeds, Infections, Discharge, Stuffiness, Itching, Snoring, Sores
6. **Mouth and Throat**: Dry Mouth, Frequent sore throat, Hoarseness, Postnasal Drip, Bleeding gums, Tooth pain
7. **Neck**: Lumps, Pain on movement, swollen glands, thyroid trouble
8. **Chest**: Cough, Coughing up blood or sputum, Shortness of Breath, Wheeze
9. **Cardiac**: Chest Pain, Chest Pressure, Palpitations, Waking up in the Night Short of Breath, Shortness of Breath with minimal exertion
10. **Vascular**: Pain in the Legs, Calves, Thighs or Hips While Walking, Leg Swelling, Loss of Hair on Legs, Ulcers
11. **Breasts**: Lumps, Nipple Discharge, Pain, Tenderness, Skin Changes
12. **Gastrointestinal**: Change in Appetite, Nausea, Vomiting, Heartburn, Constipation, Diarrhea, Black Stools, Blood in your Stool, Trouble Swallowing, Abdominal Pain
13. **Urinary**: Urinary Frequency, Urinary Urgency, Difficulty in Starting Urine Stream, Incontinence of Urine, Excessive Urination, Pain on Urination, Blood in Urine, Number of times you urinate at Night?_____
14. **Male**: Hernias, Penile Discharge, Impotence, Testicular Pain, Testicular Mass, Sores, Difficulty getting or maintaining an Erection, Sexually Transmitted Diseases
15. **Female**: Vaginal Lesions, Itching, Sores, Abnormal Discharge, Hernia, Sexually transmitted diseases, Spotting between periods, Spotting after menopause, Decreased Sex Drive
16. **Musculoskeletal**: Muscle Pain, Joint Pain, Stiffness, Arthritis, Back Pain
17. **Neurologic**: Fainting, Seizures, Blackouts, Weakness, Paralysis, Numbness, Strokes, Tremors, Loss of consciousness, speech disorder
18. **Mood**: Nervousness, Anxiety, Depression, Suicidal Thoughts, Insomnia, Feelings of hopelessness