CHARIS PHYSICIANS HOUSECALLS PLLC
P.O. BOX 1734
ROWLETT , TX 75030-1734
PHONE: 469-366-9239
FAX: 866-700-8688
Email: office@charisphysicians.com
Website: www.charisphysicians.com

DR. JOHN ROSELL, MD
ROSELINE ONWUELEZI, FNP

PATIENT REGISTRATION/INTAKE FORM

Patient's Legal Name: _____
Last First M.I. (Maiden)

Other Names Known by: _____

Home Address: _____
State Zip

Mailing Address: _____
Street/PO Box City State Zip

Home Ph#:_____ Work Ph#:_____

Sex: F ☐ M ☐

Marital Status: ☐ Single ☐ Married ☐ Child/Infant ☐ Spouse's Name:

Ethnicity: ☐ American Indian ☐ Asian ☐ African American ☐ Filipino ☐ Hispanic
☐ Caucasian ☐ Pacific Islander ☐ Other Non-Caucasian

Occupation: _____ Name of Employer: _____

U.S. Veteran: ☐ Yes ☐ No Service Branch: _____

Vietnam Vet: ☐ Yes ☐ No Separation Date: _____

Father's Name: _____

Mother's Maiden Name: _____

Person to Contact In Case of Emergency: _____
Name Relationship:_____

_____
Street City State Zip

Phone # _____

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MEDICAL PATIENT/HEALTH HISTORY(ADULT)

Chart # _____

Name of Patient: _____
Last Name First Name Nickname: Middle Initial

What is the name of your medical doctor? _____

Has there been any change in your general health this past year? Yes☐ No☐

If yes, please describe the changes: _____

Are you in pain now? Yes☐ No☐ If yes, please describe _____

List any medications (pills or drugs) that you are currently taking: _____

List any other medications you have taken in the last two months: _____

Are you allergic to anything? Yes☐ No☐ If yes, please list drug(s) and reactions(s): _____

Past Medical History (Check all that apply):

- ☐ Alcoholism
- ☐ Angina
- ☐ Asthma
- ☐ prostatic
- ☐ Cancer
- ☐ Circulation problem
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Mental Illness
- ☐ Migraine headaches
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis Allergies
- ☐ Peptic ulcer Anemia
- ☐ disease
- ☐ Seizure disorder Anxiety
- ☐ Stomach/Duo- Arthritis
- ☐ denal ulcer
- ☐ Thyroid disease Benign
- ☐ Valve disease hypertrophy

	Year		Year
☐ Atrial fibrillation	_____	Heart Attack	_____
☐ Blood clots	_____	Heart Failure	_____
☐ CVA (stroke)	_____	Renal Disease	_____

Past Surgical History (Check all that apply):

	Year		Year
Angioplasty	_____	Heart valve replacement	_____
Angio w/stent	_____	Hernia Repair	_____
Appendectomy	_____	Hip replacement	_____
Back surgery	_____	Knee surgery	_____
Bypass surgery	_____	LASIK	_____
Carpal tunnel release	_____	Liver biopsy	_____
Cataract extraction	_____	Lower Extremity vascular surgery	_____
Colectomy	_____	Pacemaker	_____
Colostomy	_____	Small bowel resection	_____
Gall bladder surgery	_____	Thyroidectomy	_____
Gastric Bypass	_____	Tonsillectomy	_____

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HEALTH HISTORY (ADULT)

Chart # _____

Name of Patient: _____
Last Name First Name Middle Initial

Sex: ☐ M ☐ F Age: _____ Birth date: _____ Nickname: _____

What is the name of your medical doctor? _____

Has there been any change in your general health this past year? Yes ☐ No ☐ If yes, please describe the changes: _____

List any medications (pills or drugs) that you are currently taking: _____

List any other medications you have taken in the last two months: _____

PLEASE CHECK ☑	Yes	No
1. Have you received medical care in the past two years? If yes, what for? _____	☐	☐
2. Have you ever been hospitalized? If yes, what for? _____ When? _____	☐	☐
3. Do you have any allergies? If yes, what? _____	☐	☐
4. Have you ever had an allergic reaction to latex products? If yes, what reaction did you have? _____	☐	☐
5. Have you ever had a bleeding problem that needed medical treatment?	☐	☐
6. Do you ever have chest pain?	☐	☐
7. Do you use alcohol?	☐	☐
8. Do you use street drugs? If yes, what? _____	☐	☐
9. Do you use tobacco products?	☐	☐
10. Do you have reason to believe you have been exposed to AIDS or HIV?	☐	☐
11. Have you ever had radiation or chemotherapy? When? _____ For What? _____	☐	☐
12. Do you have Diabetes? What type? _____	☐	☐
13. Does anyone in your family have Diabetes?	☐	☐

FEMALES ONLY – Are you:

1. Pregnant Due Date: _____	☐	☐
2. Taking birth control pills	☐	☐
3. Currently nursing	☐	☐

Have you ever had the following?	Yes	No
14. Congenital (born with) heart problems	☐	☐
15. Heart Surgery/other open heart surgery	☐	☐
16. Rheumatic Fever	☐	☐
17. Heart valve replaced	☐	☐
18. Pacemaker	☐	☐
19. High Blood Pressure	☐	☐
20. Heart Attack	☐	☐
21. Stroke	☐	☐
22. Anemia	☐	☐
23. Tuberculosis (TB)	☐	☐
24. Asthma	☐	☐
Do you use an inhaler?	☐	☐
25. Sinus Trouble	☐	☐
26. Hepatitis What type? _____	☐	☐
27. Liver problems	☐	☐
28. Kidney problems	☐	☐
29. Cancer or tumors If yes, please describe: _____	☐	☐
30. Arthritis/rheumatism	☐	☐
31. Artificial Joint What Joint? _____ Date placed: _____	☐	☐
32. Blood transfusions	☐	☐
33. Ulcers	☐	☐
34. Epilepsy	☐	☐
35. Seizures What type? _____	☐	☐
36. Nervous or mental disorders	☐	☐

Do you have any disease, condition, or problem not listed? ☐ ☐ If yes, specify: _____

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Signature of Patient Date

I OR OFFICE USE ONLY

NOTES: (For CFC Staff) _____ For Office Use Only: Date: _____ Reviewer: _____

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Family History (Check all that apply):

Please indicate if your mother, father or sibling has any of the following diseases now or if it was their cause of death (COD).

	Mother		Father		Sister(s)		Brother(s)	
	Now	*COD*	*Now*	*COD*	*Now*	*COD*	*Now*	*COD*
CVA (stroke)								
Diabetes								
Heart disease								
Heart disease before 60								
Heart failure								
High blood pressure								
High cholesterol								
Renal disease								

Please indicate if your mother, father or sibling has had any of the following diseases:

Alcoholism								
Allergies								
Alzheimer's disease								
Asthma								
Blood disease								
Cancer								
Circulation Problems								
Depression								
Development delay								
Eczema								
Irritable bowel disease								
Learning disability								
Mental Illness								
Migraines								
Obesity								
Seizure disorder								
Other family history:								

Immunizations (Approximate dates are fine):

Date of last flu shot?_____ ☐ None Date of last pneumonia shot: _____ ☐ None

Date of last tetanus shot: _____ ☐ None

Social History (Check all that apply):

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner

Language: ☐ English ☐ Spanish ☐ Chinese ☐ French Other: _____

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian Other: _____

☐ Native American: Tribe

Who lives at home?

Name:_____ **Age:** _____ **Name:**_____ **Age:**_____

Relationship: _____ **Relationship:** _____

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What is your **tobacco** use history?

Uses tobacco: ☐ Currently ☐ Never ☐ Formerly

Tobacco type: ☐ Cigarettes ☐ Chewing ☐ Cigar ☐ Pipe ☐ Smokeless ☐ Snuff

Amount per day: ☐ (packs, ounces, cigars, pipes, units) per day Number of Years: ☐☐

Tobacco cessation discussed: ☐ Yes ☐ No Passive smoke exposure: ☐ Yes ☐ No

What is your **alcohol** use history?

Drinks alcohol: ☐ Yes ☐ No ☐ Formerly

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Drinks caffeine: ☐ Yes ☐ No

Type of **Exercise (please choose up to three):**

☐ Cycling ☐ Jogging/Running ☐ Tennis ☐ Weights ☐ Golf ☐ Swimming

☐ Walking ☐ Yoga Other: _____

Exercise Frequency: ☐ 2-3 times/week ☐ 3-4 times/week ☐ Daily ☐ Occasionally ☐ Never

Fire Arms:

Fire Arms at home: ☐ Yes ☐ No # of Fire Arms: ☐ Locked Storage: ☐ Yes ☐ No

Health Maintenance:

Are you being treated by a physician now? ☐ Yes ☐ No

Date of last medical exam: Month ☐☐ Day ☐☐ Year ☐☐☐☐ ☐ None

Reason for exam: _____

Are you receiving any alternative care? ☐ Yes ☐ No

☐ Acupuncture ☐ Chiropractic ☐ Traditional Medicine Other: _____

Are you being treated by a dentist now? ☐ Yes ☐ No

Date of last dental Month ☐☐ Day ☐☐ Year ☐☐☐☐ ☐ None

Adults (35 or older):

	Month / Day / Year	None
When was your last cholesterol test?	☐☐ / ☐☐ / ☐☐☐☐	☐
Adult women only: When was your last mammogram?	☐☐ / ☐☐ / ☐☐☐☐	☐
When was your last pap smear?	☐☐ / ☐☐ / ☐☐☐☐	☐
Adult men over 50 years old only: When was your last prostate exam?	☐☐ / ☐☐ / ☐☐☐☐	☐
Adults over 50 years old only: When was your last colonoscopy?	☐☐ / ☐☐ / ☐☐☐☐	☐
Adults over 65 years old only: When was your last Dexa Scan (Osteoporosis screening)?	☐☐ / ☐☐ / ☐☐☐☐	☐

The information I have given is correct and to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature of Patient *Date*

Submit Document Button: ☐

(Submit)