Merrimack Family Medicine
Lowell General Hospital

www.merrimackfamilymedicine.com
600 Clark Road, Ste. 3
Tewksbury, MA 01876
Tele: 978-851-4141
Fax: 978-640-9840

Patient Registration

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

SS #: _____/_____/_____ Marital Status: _____ First Name Used:_____ Former Last Name: _____

Race: _____ Ethnicity: _____ Legal Gender: _____ Email: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact Preference: _____ Occupation: _____ Employer: _____

Preferred Pronouns:_____ Language Spoken: _____ Do you require an interpreter? Yes or No

PHARMACY:

Pharmacy Name: _____ Address: _____

Phone Number: _____

INSURANCE INFORMATION:

Insurance Co. Name: _____ Policy Number: _____

Policy Holder's Name: _____ DOB ____/____/____ Gender: Male – Female

Relationship: _____ Employer: _____ ☐ Check here if address is the same as the patient.

Address: _____ PCP Name & Address: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

PARENT/GUARDIAN INFORMATION: (*Fill this section <u>ONLY</u> if this registration is for a child under 18*)

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

Home Phone: _____ Cell Phone: _____ Contact Preference: Home or Cell

☐ Check here if address is the same as the patient. Current Address: _____

I hereby assign Merrimack Family Medicine all money to which I am entitled for medical and/or surgical expense relative to the service rendered by them, but not to exceed my indebtedness to them. It is understood that all money received from the above-named insurance companies, over and above my indebtedness; will be refunded to me when my bill is paid in full. I understand I am financially responsible to said practice for charges not covered by this assignment. ***I have received and red the notice of privacy practices.***

_____ _____

Patient Signature and/or Parent/Legal Guardian **Date**

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PATIENT MEDICAL HISTORY

Please complete the following questionnaire to the best of your ability. If there are any questions you prefer not answering leave them blank.

FAMILY HISTORY

Age ↓	Living	Deceased	Cause of Death
Mother -			
Father -			
Sister -			
Brother -			

Have any members of your **immediate family** had the following:

	Circle Answer	Relation
Cancer:		
• Breast	Yes / No	Mother – Father – Sister – Brother
• Colon	Yes / No	Mother – Father – Sister – Brother
• Ovarian	Yes / No	Mother – Father – Sister – Brother
• Uterine	Yes / No	Mother – Father – Sister – Brother
Diabetes	Yes / No	Mother – Father – Sister – Brother
Endometriosis	Yes / No	Mother – Father – Sister – Brother
Fibroids	Yes / No	Mother – Father – Sister – Brother
Heart Disease	Yes / No	Mother – Father – Sister – Brother
High Blood Pressure	Yes / No	Mother – Father – Sister – Brother
Kidney Disease	Yes / No	Mother – Father – Sister – Brother
Stroke	Yes / No	Mother – Father – Sister – Brother
DVT (Blood Clot)	Yes / No	Mother – Father – Sister – Brother

MEDICATIONS: Please list all prescription and non-prescription medicine

Medication Name	Dose	Frequency

ALLERGIES: Please list all known allergies

Allergy	Reaction or Side Affect

SURGICAL HISTORY AND HOSPITALIZATIONS: Does not refer to pregnancies

Surgery / Hospitalizations / Name of Hospital	Date

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PERSONAL MEDICAL HISTORY

Immunizations:	**Circle Answer**	**Year**
Chicken Pox	Yes / No	_____
Measles – Mumps – Rubella (MMR)	Yes / No	_____
Hepatitis B	Yes / No	_____
Tetanus	Yes / No	_____
Gardasil	Yes / No	_____
Influenza (Flu)	Yes / No	_____

Have you ever had the following problems?	**Circle Answer**	**Year**
Anemia	Yes / No	_____
Bone Disease	Yes / No	_____
Cancer	Yes / No	_____
Depression/Anxiety	Yes / No	_____
Diabetes	Yes / No	_____
Heart Problems	Yes / No	_____
Hepatitis	Yes / No	_____
Hypertension	Yes / No	_____
Immune Disorder	Yes / No	_____
Kidney Problems	Yes / No	_____
Migraine Headaches	Yes / No	_____
Muscle Disease	Yes / No	_____
Thrombophlebitis	Yes / No	_____
Any Reactions to Anesthesia	Yes / No	_____
MRSA / VRE	Yes / No	_____
Blood Transfusions	Yes / No	_____
Are Blood Transfusions acceptable to you?	Yes / No	

PREGNANCY HISTORY: Please list ALL pregnancies OR new pregnancies since last visit.

How many times have been pregnant? _____ How many children have you had? _____

Month/Year	Place of Delivery	Length of Pregnancy	Type of Delivery	Complications	Gender	Birth Weight	Present Health

MENTRUAL HISTORY

Do you still have a period? Y / N
If not, age at which you stopped? _____
Age of first menses? _____
Any problems with your periods? Y / N
Date of last menstrual period? _____

PAPSMEAR / MAMMOGRAM HISTORY

Date of last pap? _____
Have you ever had an abnormal pap: Y / N Date: _____
Date of last mammogram? _____
Have you ever had an abnormal mammogram? Y / N Date: _____

SOCIAL HISTORY

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CONTRACEPTION

Are you currently sexually active? Y / N
Current sexual partner? Male or Female
Method of birth control currently? _____

Smoker? Y / N Never Former
Alcohol? Y / N Never Frequency? _____
Recreational drugs? Y / N Frequency? _____
Seat belt use? Y / N Exercise? Y / N Frequency? _____
Are you safe at home? Y / N
Any history of abuse or violence in your relationships? Y / N