

**John M. Pramenko, MD, P.C.**



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**Registration**

Name \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ SS# \_\_\_\_\_

Race: White \_\_\_ Black/African American \_\_\_ Latino \_\_\_ Asian \_\_\_ Native American \_\_\_ Other \_\_\_

**Head of Household / Guarantor (If different from above):**

Name \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ SS# \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

**Insurance Information:**

Primary Insurance \_\_\_\_\_ ID number \_\_\_\_\_

Policyholders name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID number \_\_\_\_\_

Policyholders name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

## Adult Health History

### Medical Problems (check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Breathing problems / Lung disease | <input type="checkbox"/> Liver Disease                 | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart Disease                     | <input type="checkbox"/> Stomach / intestinal problems | <input type="checkbox"/> Blood clots     |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Skin disease                  | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> High blood pressure               | <input type="checkbox"/> Tuberculosis                  | <input type="checkbox"/> Mental Illness  |
| <input type="checkbox"/> Menstrual Problems                | <input type="checkbox"/> High cholesterol              | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Stroke                            | <input type="checkbox"/> History of drug/alcohol abuse | <input type="checkbox"/> Kidney disease  |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Sleep disorder  |
| <input type="checkbox"/> Cancer – what kind? _____         |  |  |
| <input type="checkbox"/> Other _____                       |  |  |

### Other Medical History

- |                              |                      |
|------------------------------|----------------------|
| Last HIV test _____          | Last pap smear _____ |
| Transfusion (when)? _____    | Last mammogram _____ |
| Last tetanus shot _____      | Colonoscopy? _____   |
| Surgeries _____              | _____                |
| _____                        | _____                |
| _____                        | _____                |
| Medications _____            |                      |
| _____                        |                      |
| _____                        |                      |
| _____                        |                      |
| Allergies to medicines _____ |                      |
| Other allergies _____        |                      |
| Previous doctor _____        | Where? _____         |

### Family History (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Mental Illness             |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Drug/alcohol abuse         |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Bleeding/clotting disorder |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> High blood pressure        |
| <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> Cancer – what kind _____ |   |
| <input type="checkbox"/> Other _____              |   |