NEW PATIENT REGISTRATION

WILLIS-KNIGHTON HEALTH SYSTEM

Patient name_____Age _____ MR # _____ Date _____

Allergies:
Current medications:

Reason for today's visit: (chief complaint)

_____

_____

_____

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	❑	❑	_____
Eyes	❑	❑	_____
Ears/Nose/Throat/Mouth	❑	❑	_____
Heart	❑	❑	_____
Lungs	❑	❑	_____
Stomach/bowel	❑	❑	_____
Kidneys	❑	❑	_____
Arthritis/muscles/joints	❑	❑	_____
Skin	❑	❑	_____
Headaches/seizures	❑	❑	_____
Psychological disorder	❑	❑	_____
Thyroid/diabetes	❑	❑	_____
Blood/bleeding disorder	❑	❑	_____
Allergic/immunologic	❑	❑	_____

Females: are you pregnant? __yes __no planning to become pregnant? __yes __no

Family History: (Past family & social history)

Mother: living/deceased_____age___ Father: living/deceased_____age___No. of children__ age(s)_____

Check following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative
Allergies	❑	❑	❑
Arthritis	❑	❑	❑
Asthma	❑	❑	❑
Cancer	❑	❑	❑
Diabetes	❑	❑	❑
Eczema	❑	❑	❑
Hayfever	❑	❑	❑
Heart disease	❑	❑	❑
High blood pressure	❑	❑	❑
Lung disease	❑	❑	❑
Malignant Melanoma	❑	❑	❑
Psoriasis	❑	❑	❑
Skin cancer	❑	❑	❑
Tuberculosis	❑	❑	❑

Social History:

Do you live alone? __no __yes
Do you drink alcohol? __no __yes-frequency _____
Occupation _____

Do you smoke? __no __yes-frequency- _____
Do you use recreational drugs?__no __yes-frequency _____
Hobbies/leisure activities

Reviewed_____ Date_____ Update _____
(MD signature)

Patient name_____Age_____MR # _____Date _____

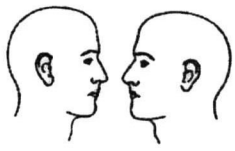
Skin Type: I II III IV V

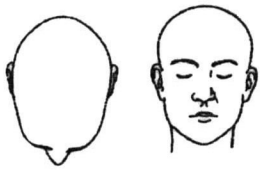
Constitutional: • (vital signs) - at least 3 of the following 7 must be measured: BP-sitting or standing_____supine_____
pulse rate & regularity_____ respiration_____ temperature_____ height_____ weight_____
• general appearance _____
(eg, development, nutrition, body habitus, deformities, attention to grooming)

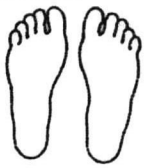
		Normal	Abnormal	Notes
Eyes -	• conjunctivae and lids	❑	❑	
ENMT -	• lips, teeth and gums	❑	❑	
	• oropharynx	❑	❑	
Neck -	• thyroid	❑	❑	
Cardiovascular-	• peripheral vascular system	❑	❑	
Gastrointestinal	• liver and spleen	❑	❑	
	• anus	❑	❑	
Lymphatic -	• lymph nodes	❑	❑	
Extremities -	• digits and nails	❑	❑	
Skin -	• scalp and body hair	❑	❑	
	(for comprehensive 8 of following 10 required)			
	• head including face	❑	❑	
	• neck	❑	❑	
	• chest, including breasts and axilla	❑	❑	
	• abdomen	❑	❑	
	• genitalia, groin, buttocks	❑	❑	
	• back	❑	❑	
	• right upper extremity	❑	❑	
	• left upper extremity	❑	❑	
	• right lower extremity	❑	❑	
	• left lower extremity	❑	❑	
	• eccrine and apocrine glands	❑	❑	
Neuro/Psych -	• orientation	❑	❑	
	• mood and affect	❑	❑	

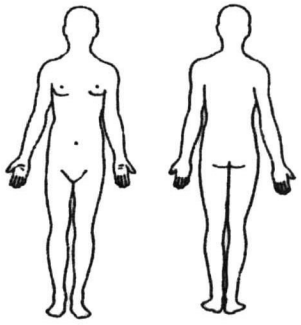
Documentation requirements:

Problem focused	-1-5 elements identified by a bullet
Expanded problem focused	-at least 6 elements identified by a bullet
Detailed	-at least 12 elements identified by a bullet
Comprehensive	-all bullet items; every element as required in Constitution, Ear, Nose, Eyes, Throat and Skin; at least one element in other areas









Test results _____

Clinical impression_____

Treatment plan _____

MD Signature _____

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