

DR. MO PEDIATRIC CENTER

1021 Karl Greimel Drive, Suite 100 Brighton, MI 48116

Telephone: (810) 220 DRMO (3766)

Original Date:
Dates Revised:

Name (Last, First, M.I.):

M F

DOB:

Social Status Single

REGISTRATION INFORMATION

Patient's Social Security Number:

Home Street Address:

City: State: ZIP Code:

Telephone Number: Emergency (alternative) number:

Mother's Occupation: Work Phone Number:

Father's Occupation: Work Phone Number:

Parents: Married Not Married Separated Divorced Deceased: (Father, Mother)

Child Lives with: Both Parents Mother Father Grand Parent Other (Please Specify)

FOR OFFICE USE ONLY

REG #

FILE #

BILLING AND INSURANCE INFORMATION

Person Responsible for Bill:

Date of Birth:

Address (if Different):

Home (or Cell) Phone:

Relation to Patient:

Occupation: Employer:

Employer Address:

Employer (Work) Phone Number:

Primary Insurance:

Subscriber's Name: Subscriber's SS#: DOB: / /

Group Number: Policy Number: Co-payment: \$

Name of Secondary Insurance (if Applicable):

Subscriber's Name: Subscriber's SS#: DOB: / /

Group Number: Policy Number: Co-payment: \$

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY (FILL OUT AS APPROPRIATE)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., sports or recreation less than 4 times a week)		
	<input type="checkbox"/> Regular vigorous exercise (sports or recreation 4 times a week for 30 or more minutes)		
Safety (age appropriate)	<input type="checkbox"/> Wears helmet <input type="checkbox"/> Wears protective gear during sport activities <input type="checkbox"/> Knows own address and phone number(s) <input type="checkbox"/> Supervised while swimming or playing <input type="checkbox"/> Potentially hazardous materials out of reach <input type="checkbox"/> No firearms or weapons within reach.		
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	Relatives	AGE	SIGNIFICANT HEALTH PROBLEMS
Father				<input type="checkbox"/> M <input type="checkbox"/> F	
Mother					
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH: QUESTIONS FOR ADOLESCENTS (13-18 YEARS)

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FEMALES ONLY

Age at onset of menstruation: _____

Date of last menstruation: _____

Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date of last pap and rectal exam? _____

OTHER ISSUES? PLEASE DESCRIBE:

MALES ONLY

Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder infection within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER ISSUES? PLEASE DESCRIBE:

OTHER PROBLEMS

Check if you have, or have had, any signs or symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	<input type="checkbox"/> Other