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Patient Registration

Name _____ Birthdate _____ Age _____
Sex M ___ F ___ Marital Status M ___ S ___ W ___ D ___
Phone: Home _____ Cell _____
Daytime _____ Email Address: _____
Address: _____

Employer: _____ Occupation _____
Who you referred you to our office? _____
Emergency contact info: Name _____ Phone _____
Is this visit related to an injury? Y ___ N ___ Work related Y ___ N ___ Auto Accident Y ___ N ___

Name of Spouse or Guardian _____ Relationship _____
Spouse's employer _____ Occupation _____
Work phone _____

Primary Insurance

Insurance Company _____ Phone _____
Insurance Company Address _____
Policyholder's name _____ Relationship to patient _____
ID# _____ Group # _____
Employer of insured _____ Work Phone _____
Primary insured's date of birth: _____

Please present your health insurance card with this form.

Secondary Insurance

Insurance Company _____ Phone _____
Address of Insurance Company _____
Policyholder's name _____ Relationship to patient _____
ID# _____ Group # _____
Employer of insured _____ Work Phone _____

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance company, or companies, all and any information necessary to process any claim. I further authorize that payment(s) be made directly to the doctor.

Signature _____ Date _____

Health History

Full Name: _____ Age: _____ Today's Date _____

Past History

Major Illnesses—names and dates: _____

Previous hospitalizations and surgeries:

Well Being

What practices or activities do you use to sustain your health and well being? (Religious/spiritual/what inspires you?)

Goals for health:

Who do you turn to for support?

What causes stress for you?

Diet: Fast Food All American Vegetarian Balanced Other _____

Smoking: Y N Packs per day _____ Number of years _____ Years stopped _____ Pipe Cigar Chew

Alcohol: Never Occasional Moderate Heavy

Exercise Never Occasional Moderate What kind of exercise? _____

Caffeine: Coffee _____ cups per day Tea: _____ cups per day

Height: _____ Weight: _____ Weight at 20: _____ Weight change last year: Gain _____ # Lost _____ #

Occupational exposures: _____ Asbestos _____ Other _____

List all prescription drugs you are on: (Make sure to be complete to avoid drug interactions). Please give dose and frequency:

List all supplements and herbs you take:

Allergies:

Drug Allergies _____

Date of last medical exam: _____ Date of last dental exam: _____

Date of last chest x-ray: _____ Date of pap smear _____

Date of last eye exam: _____ Date of last EKG _____

Date of last sinus infection: _____ Date of last bladder infection: _____

Family History (circle and then list family member at right)

Diabetes _____ Ulcers _____

Heart trouble _____ Mental Illness _____

Heart Attack _____ Thyroid trouble _____

High blood pressure _____ Stroke _____

Cancer (list type) _____

Tuberculosis _____ Alcoholism _____

Drug problems _____ Other (list) _____

Health History

Please state your chief complaint or reason for coming to the doctor

Who else have you seen for this condition:

Organ System Review: Please circle if you have any symptoms or problems to any significant degree

Tired all the time	Frequent colds	Indigestion	Sugar in urine
Don't feel well	Bronchitis	Heartburn	Hypoglycemia
Weight Problem	Pneumonia	Nervous stomach	Low blood sugar
Fluid Retention	Shortness of Breath	Ulcers	Thyroid trouble
Headache	Pleurisy	Vomiting Blood	Bladder problems
Migraine	Chest Pain	Black or bloody stools	Kidney infection
Fainting	Heart Trouble	Rectal bleeding	Kidney trouble
Dizziness	Heart Murmur	Abdominal pain	Kidney Stones
Epilepsy/Seizures	Heart palpitation/racing	Nervous/spastic colon	Difficulty urinating
Ear/hearing problems	Chest tightness/pressure	Colitis	Protein in urine
Ringing in ears	Angina	Diarrhea	Blood in urine
Stuffy Nose	Tire Easily	Constipation	Skin rash
Hay Fever	Enlarged Heart	Change in bowel habits	Skin trouble
Sexually Trans.Disease	Rheumatic Fever	Hepatitis	Allergy
Nose bleeds	Leg pain on walking	Liver disease	Food avoidance
Sinus trouble	Phlebitis	Hernia	Bleed or bruise easily
Persistent hoarseness	Ankle/leg swelling	Food intolerance	Anemia
Glasses	Arthritis/joint pain	Nervous	Blood disease
Vision/eye trouble	Gout	Tense/Irritable	Infertility problem
Glaucoma	Neck pain	Bored	Sexual difficulty
Cataract	Back pain or trouble	Depressed	Trouble sleeping
Frequent cough	Bursitis/tendonitis	Relationship problems	Job problems
Cough phlegm	Trouble swallowing	Personal problems	Psychiatrist seen
Cough blood	Nervous breakdown	High blood sugar	

Men Only:

Discharge from Penis Prostate Trouble Stream weak or slow Swelling or pain in testes

Date of vasectomy: _____

Women Only:

Age menses began: _____ Periods: _____ Regular Irregular Date of Last Period _____

Vaginal Discharge Y N Hot flashes Y N Breast Lump or Discharge Y N

Number of Miscarriages or abortions: _____ Date of Last Mammogram: _____

Type of birth control _____ IUD Y N Date of insertion _____

Please list pregnancy dates and outcomes: _____

Physician Use Only: