445 LINCOLN DRIVE

SPRINGFIELD KY 40069

859.336.7731

PATIENT REGISTRATION/CONSENT FORM

(PLEASE PRINT)

Name_____ Date of Birth_____

Male Female (circle) Race (circle) White, African American, Hispanic, Other

Street Address:_____

City_____Zip Code_____

Social Security #_____Pharmacy_____

Marital Status (circle) Single/Married/Divorced/Widow

Employment Status: (circle) Employed, Unemployed, Retired, Student

Employer Name:_____Occupation_____

Home Phone(___)_____Work(___)_____Cell(___)_____

Emergency Contact:_____(___)_____

Relationship_____

Patient History Form
Taylor Family Practice
Dawn C. Taylor, MD

Name_____Age_____Date of Birth_____

Are you allergic to any medications? No___ Yes ____,List_____

List all medications you are taking including non-prescription and over the counter:

_____ _____
_____ _____
_____ _____
_____ _____

Medical History –Circle:

High Blood Pressure
High Cholesterol
Diabetes/Pre-Diabetes
Heart Disease (MI, Bypass, Stent)
CHF (Enlarged Heart)
A.Fib (other Irregular Heart Beat)
Asthma
COPD/Emphysema
Anemia
Cancer (specify)_____
Depression/Anxiety
Thyroid Disease
Arthritis
Back/Neck Problem
Osteoporosis
Vitamin Deficiency (B12, Vit D)
Liver Disease (Hepatitis, Fatty Liver)
Kidney/ Bladder/ Colon Problem
Reflux/ Bleeding Ulcers
Other (s)_____

Surgeries – List with Date if Possible:

Social History – Circle:

Tobacco Use Yes/ No/ Quit Date_____
Alcohol Use Yes/ No/ Quit Date_____
Single/Married/Divorced/Widowed/Significant Other
Student/Employed/Retired/Unemployed/Disabled
 # Of Children _____Sons _____Daughters
Exercise _____ (days/wk)
Illegal Drugs Yes/ No/ Quit Date _____
Occupation_____

Family History (list chronic medical problems (s) of your parents & Siblings):

Mother:_____Father_____Siblings_____

Health Maintenance:

Mammogram _____
Pap Smear _____
Blood Sugar A1c_____
PSA/Prostate Check _____
Colonoscopy _____
Tetanus Shot _____
Bone Density _____
Cholesterol Test _____
Pneumonia Vac _____