Dr. Michael S Duffy SR, DO
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Office: 619-461-3717 Fax: 619-461-5663

New Patient Registration / Medical History

Patient Name: _____ Date: _____
Patient DOB: _____ □Male □ Female
Physical Address: _____
Phone Number: _____
Emergency Contact (Number and Relation):
_____

Primary Insurance: _____Policy #_____Group_____
Are you the Cardholder □ Yes □ No Cardholder _____Relation_____
Secondary Insurance: _____Policy #_____Group_____
Are you the Cardholder □ Yes □ No Cardholder _____ Relation_____
Social Security Number: _____
Primary Care Physician: _____
Phone Number: _____
Email Address: _____

Medical History

1. Allergies (Please list all): _____
   _____
   _____
2. If you require assistance to walk what device do you use:
   _____
   _____
3. Nutritional Status (do you have dietary needs):
   _____
4. What prescription Medication, Over the Counter(OTC's) and/or Herbals are you currently taking?

Medication Name	Medication Strength	Medication Dosage

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5. Who do you use for your primary Pharmacy?

Name	Address	Phone Number

6. Are you currently seeing any other providers? _____ If So please list their Name and Specialty.

Physician Name	Specialty	Phone # if Known

7. Present Medical Complaint: _____

8. Past Medical History, Major Illness, Hospitalization, Surgeries (include dates):

9. History of Trauma (Physical/ Sexual/ Verbal): □ Yes □No, If yes please describe:

10. Psychiatric History: □ Yes □ No If Yes Please explain:

11. Family Substance History: Does anyone in your family have a substance use problem?
□Yes □No If yes please describe (Who, What, How Much and How Often)

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12. Family Psychiatric History: Does anyone in your Family Have a Psychiatric Illness: □Yes □No If yes please describe (who, what):

13. Family medical history of illness/Disease: Please describe any Illness/Disease that your Family has had (Who, What, When)

Review of Systems

Please list any problems that you have with the following body system:
Ears/ Nose/ Throat: □Do not have any problem □Have the following

Eyes: □Do not have any problem □Have the following

Lungs: □Do not have any problem □Have the following

Liver: □Do not have any problem □Have the following

G-I Tract (Stomach, Intestines, Bowels, Etc.): □Do not have any problem □Have the following

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Kidney/ Bladder: □Do not have any problem □Have the following

Reproductive System: □Do not have any problem □Have the following

Skin: □Do not have any problem □Have the following

Neurological: □Do not have any problem □Have the following

Heart/ Circulation: □Do not have any problem □Have the following

Psychological (Depression, Anxiety, and Anger Etc.): □Do not have any problem □Have the following

Off Work Activities

Do you Exercise? □Yes □No if yes please describe the type of exercise and the frequency you exercise. If no, please explain why you do not exercise:

DO you participate in any sports or other physical activities? □ Yes □No If yes, please describe type and the frequency you participate in activities:

Do you have any hobbies? □ Yes □NO If yes please describe type and the frequency you do hobbies:

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Are you able to perform your normal/ regular house/ yard chores/ activities?
□Yes □No If no please explain what you cannot do and why:

_____
_____
_____
_____

Social History

Are you: □Married □Single □Separated □Divorced □Separated □Divorced
□Widowed If married, how many years: ____ If separated, how many years? ____
If divorced, how many years? ____ If widowed, how many years? _____

How many years of schooling do you have? _____

Did you have problems in school? □Yes □No If yes, please explain (How, What, Who With):

_____
_____
_____
_____
_____

What is the highest degree you earned?
□GED □High School Graduate □BS □MS □Doctorate
□Other:_____

What licenses/ certifications do you have:

_____
_____
_____
_____
_____

Do you use alcohol? □Yes □No If yes, how many drinks per week?
_____
If Quit When and how much did you consume_____
Do you use Tobacco? □Yes □No If yes, how many times per day? _____
If Quit When and how many Packs per Day_____
If Interested in quitting have you tried anything so far □Yes □No
Have you set a quit date □Yes □No Date:_____
Would you like info on smoking cessation □Yes □No
Do you chew Tobacco? □Yes □No If yes, how many times per day? _____
If you Quit When and How much did you Use_____
If Interested in quitting have you tried anything so far □Yes □No

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Have you set a quit date ☐Yes ☐No Date:_____
Would you like info on smoking cessation ☐Yes ☐No

Do you use medical Marijuana? ☐Yes ☐No If yes how often and how much?
_____

Do you use any other kind of drugs? ☐Yes ☐No If yes, what kind and how often?
_____
_____
_____
_____

List any other Habits that you have, describing their types and frequency:
_____
_____
_____

If Todays Visit is to be billed to WORKERS COMPENSATION The Following Questions. MUST be COMPLETED, (Otherwise Skip ahead to consent and Signatures)

1. Were you injured on the job? ☐ Yes ☐ No If yes describe how your injury occurred (Include date of injury and all body parts affected) :
_____
_____
_____
_____
_____
_____
_____

2. How did your symptoms come on? ☐Gradually ☐Suddenly If Gradually, over what time period, and how did you realize you were injured?
_____
_____
_____
_____

3. When did you first seek treatment? _____. Did your employer send you for treatment? ☐ Yes ☐No

Did you go to the hospital/ emergency Room? ☐Yes ☐ No If yes please provide the name of the hospital? _____

Were you admitted to the hospital? ☐Yes ☐ No If yes for how long:
_____

What did the doctors say was wrong with you? : _____

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Describe any testing done and type of treatment received:

Did they restrict your duties and activities: □ Yes □ No If yes please describe:

4. Please list all doctors you have seen for your injury providing dates and treatment provided:

5. Employer at time of injury:

6. Claims Adjustor Name and Phone Number:

7. Your Workman's Compensation Claim Number:

8. Attorney's Name and Phone Number:

9. Are you still working for the same employer where your injury occurred? □Yes □No If No please explain why you are not working for the same employer:

10. If you are not working for the same employer as when you were injured please list your employment since leaving:

□I have not worked since leaving my employment.

Current Employer(s)	Date of Employment	Reason For Leaving	Job Title/ Duties

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_____ _____

Patient's Signature Date