Eastern Comprehensive Medical Services, P.C.

152 Madison Avenue Suite 1700, New York, N.Y. 10016
Telephone: (212) 889-6540 Fax: (212) 889 4987

196 Canal Street, 3th & 4th Floor, New York, NY 10013
Telephone: (212) 227-6500 Fax: (212) 227-7550

39-07 Suite 4B, Prince Street, Flushing, N.Y. 11345
Telephone: (718) 886-8258 Fax: (718) 886-8348

11 Monroe Street, First Floor, New York, N.Y. 10002
Telephone: (212) 962-1107 Fax: (212) 962-5969

New Patient Registration Form

Please write in English

Gender： **Male** ☐ **Female** ☐

Last Name： ________________________

First Name： ________________________

Middle Name： ________________________

Birth Date： _______ ／ _______ ／ _______

Social Security Number： (______) _______ - ______

Home Phone Number： (______) _______ - _______

Cell Phone Number： (______) _______ - _______

Work Phone Number： (______) _______ - _______

Street Address， Apartment

____

City， State， Zip Code

________________________ , ___________ , ___________

Emergency Contact Name： ______________________________

Phone Number： _____________________________________

Referring Physician： ______________________________

SIGNATURE： **X** ____

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Patient Questionnaire

Name: ________________Referring Doctor: ____________Accompanied by: ______________
Ethnic background: _______________________
What is the reason for your visit today? ____
Do you have any of the following symptoms? Please check.
General constitutional: [ ] Fever [ ] Chills [ ] Fatigue Eyes: [ ] Visual changes
ENT: [ ] Ear pain [ ] Sore throat Cardiovascular: [ ] Chest pain [ ] Palpitations
Respiratory: [ ] Cough [ ] Shortness of breath
Genitourinary: [ ] Dysuria [ ] Hematuria
GI: [ ] Abdominal pain [ ] Nausea [ ] Constipation/Diarrhea
Endocrine: [ ] Tremors [ ] Palpitations [ ] Intolerance of heat/cold [ ] Polyuria [ ] Polydispsia [ ] Polyphagia [ ]Diaphoresis
Skin: [ ] Change in skin [ ] Rash [ ] Sores
Musculoskeletal: [ ] Joint pain [ ] Numbness [ ] Tingling [ ] Weakness of Limbs
Neurological: [ ] Dizziness [ ] Syncope [ ] Seizures
Psychological: [ ] Normal affect [ ] Depression [ ] Anxiety [ ] Psychosis

Are you currently taking medications [ ] No [ ] Yes
Please list current medications: ____
Past medical history, please check.
[ ] Hypertension [ ] Hypercholesterolemia [ ] Diabetes [ ] Hepatitis [ ] Gastritis
[ ] GI Reflux [ ] Coronary Artery Disease [ ] Heart Disease [ ] Hyperthyroidism [ ] Hypothyroidism
[ ] COPD [ ] Asthma [ ]Anemia [ ] Stroke [ ] Seizures [ ] Motor Vehicle Accident [ ]Head Injury
[ ] Cancer [ ] Sleep Apnea [ ] Attention Deficit Disorder [ ] Meniere's Disease [ ] Peripheral Neuropathy [ ]Vertigo [ ] Skin Disease [ ]Osteoarthritis [ ] Osteoporosis/Osteopenia [ ] Gout
[ ] Emphysema [ ] Pacemaker [ ]Kidney disease [ ] Liver disease [ ] Bleeding disorder [ ]Seizure disorder [ ] Spine problem [ ] Others ____

Past surgical history, please check.
[ ] Laminectomy [ ] Thyroidectomy [ ] Hysterectomy [ ] Cholecystectomy
[ ] Craniotomy [ ] Osteotomy [ ] Glaucoma Surgery [ ] Cataract Surgery
The patient uses: [ ] Wheel chair [ ] Walker [ ] Crutches [ ] cane [ ] no assistive device
The Patient lives: [ ] Alone [ ] with parents [ ] with spouse [ ] with his/her children
The Patient lives: [ ] an apartment [ ] House [ ] with stairs [ ] how many
The patient has home health aid: [ ] Yes [ ] No [ ] Hours [ ] Days
Family History: ____
Personal History/Social History:
[ ] Smoke (if yes, how much? ____)
[ ] Alcohol (if yes, how much? ____)
[ ] Drug Abuse (if yes, what kind? ____)
[ ] Allergies (please specify:____)
Level of education:______________________Occupation:_________________________
Marital status: [ ] Single [ ] Married [ ] Never married [ ] Divorced
Sexual history: [ ] Sexually active [ ] Sexually not active
Emergency contact: ________________Relation: _______________ Phone: _____________

Signature: X____________________Date:________________