Patient Registration Form

We cannot process your paperwork unless all required fields are completed (indicated in *__BOLD__ below)

*__Last Name__ *__First Name__ MI Date

Maiden Name *__Date of Birth__ Age *__Gender__ ◯ Female ◯ Male ◯ Undifferentiated

*__Race__ ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Hispanic or Latino

◯ Native Hawaiian or Other Pacific Islander ◯ White ◯ Unknown ◯ Other ◯ Decline

*__Ethnicity__ ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown ◯ Decline

*__Preferred Language__

*__Mailing Address__

*__Street Address__ if different from mailing

*__City__ *__State__ *__Zip__

*__Telephone (Home)__ __(Work)__ __(Cell)__

*__Email Address__ *__May we contact you by email?__ ◯ Yes ◯ No

*__Where may we leave messages?__ ◯ Home ◯ Work ◯ Cell

*__Where do you prefer to receive your appointment reminder message?__ ◯ Home ◯ Cell ◯ Email ◯ Text

Parent(s) / Guardian(s) Name / Healthcare proxy

Do you have advance directives? ◯ Yes ◯ No

Relationship Status ◯ Married ◯ Partnership ◯ Separated ◯ Divorced ◯ Widowed ◯ Single

Live with ◯ Spouse ◯ Partner ◯ Parents ◯ Children ◯ Friends ◯ Alone ◯ Roommates

*__Employment Status__ ◯ Employed ◯ Unemployed ◯ Full time student ◯ Part time student

Occupation Hours per week

Employer Name and Address

*__Emergency Contact__ First/Last Name *__Relationship__ *__Contact Phone__

*__Primary Care Physician__ Preferred Pharmacy

*__Primary Care Giver__

How did you hear about Biologic Healthcare?

*__Insurance Verification__: ◯ BC/BS ◯ Cigna ◯ MVP ◯ CBA ◯ Green Mountain Care Medicaid/VHAP ◯ Medicare ◯ Self-Pay

*__ID/Policy #__: *__Group/Acct #__:

*__Subscriber Full Name__: *__Subscriber/ Policyholder Date of birth__:

biologic HEALTHCARE

sensible approaches to your well-being

205 Main Street • Brattleboro, VT 05301 • 802.275.4732 • FAX 802.275.4738
www.biologichealthcare.com

Patient Health Questionnaire

Thank you for your interest in Biologic. At this time, we are accepting new patients, however we are a different type of primary care office, focusing on Lifestyle and Functional Medicine. We recognize what we offer is not right for everyone and because of this, we have an intake process for potential new patients to determine the appropriateness for our patients and the practice.

Name: Date: Birth Date: Age:

Telephone: ○ Home: ○ Cell:

Please check preferred telephone number for communication

1. What services do you most value at Biologic?

2. What is your immediate health concern?

3. What are you feeling positive about regarding our healthcare services?

4. What obstacles are preventing you from reaching your wellness goals?

5. Do you have a prefered healthcare provider at Biologic?

(continued)

Name: Date of Birth:

CURRENT HEALTH CONCERNS

Health Concern (not listed on page 1)	Current treatment?	Who is treating this?

Allergies (drug/environmental/ food)	Symptoms

Food Sensitivities	Symptoms

Current Medications	Dose	Times/Day	Current Prescriber

Current Herbs/Vitamins/Supplements	Dose	Times/Day

HEALTHCARE PROVIDERS	Provider/Group Name	Last Seen (month/year)
Primary Care Practitioner		
OB/GYN		
Dentist		
Eye Care		
Other		

Immunizations

○ Immunizations are ALL up to date ○ Behind Schedule ○ Never Immunized ○ Unknown ○ Unsure

States immunized in: ○ VT ○ NY ○ NH ○ MA ○ CT ○ Other

List childhood illnesses: _____

List prior illness, injury, hospitalization, surgery, and/or trauma (including dates):

(continued)

Name: Date of Birth:

HEALTH SCREENING HISTORY	Date of most recent	HEALTH SCREENING (cont)	Date of most recent
Mammogram		Professional Prostate Exam	
Pap Smear		Colonoscopy	
Professional Breast Exam		Lab Tests	
DEXA/Osteoporosis		Imaging (Xray, CT, MRI)/Reason	

PERSONAL/FAMILY HISTORY

* MGM (Maternal Grandmother), MGF (Maternal Grandfather), PGM (Paternal Grandmother), PGF (Paternal Grandfather), Aunt(s), Uncle(s)

	SELF	MOTHER	FATHER	SISTER(S)	BROTHER(S)	OTHER (please specify)*
Birth Date						
Age (age at death)						
Cause of death						
Check those applicable:						
Alcoholism/Substance Abuse						
Allergies/Hay Fever						
Asthma						
Anemia						
Anxiety						
Autism Spectrum Disorder						
Bleeding Disorder						
Cancer or Tumor (Specify Type)						
Chronic Fatigue						
Diabetes (Type 1 or Type 2)						
Depression						
Epilepsy						
Glaucoma/Other Eye Disorder						
Genetic Disease						
Heart Disease						
Hepatitis						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Mental Health Disorder						
Rheumatism/Arthritis						
Stomach Ulcer						
Stroke						
Thyroid Disorder						
Tuberculosis						
Other (specify)						

(continued)

Name: Date of Birth:

HOUSING

Housing type: Single family home Apartment Condo Other: _____
Children (list gender/ages): _____
Major stresses in last 12 months: Money Job Marriage Home Life Children Housing/Food Insecurity
Other stressors _____
Rate your stress level 1 to 10 on average (10 worst stress): _____ Is this a change? Yes No

DIET

Check which diet(s) you currently follow: Regular Diet Vegetarian Vegan Pescatarian Keto
Low Carbohydrate High Protein FODMAP SIBO Other: _____

EXERCISE

What type of exercise do you engage in currently? Aerobic Anaerobic Flexibility Weight Lifting None
Frequency of workout: Daily 4-6 times a week 2-3 times a week Weekly Monthly
Duration of session: <30 minutes 30-45 minutes 45-60 minutes 60-90 minutes 90+ minutes

SMOKING HISTORY

Are you a current smoker? Yes Never smoked Former smoker (when quit:___)
If yes, how many packs a day are you currently smoking? _____
How long have you been smoking for (in years)? _____
How many times have you tried to quit? 1 2 3 4+

Yes, cigarettes
Yes, e-cigarettes
Yes, vaping, juuling

RECREATIONAL DRUG HISTORY

Have you ever used recreational drugs? Yes Never used Former user
Substance(s) used: Cannabis Cocaine Benzodiazepines Opioids Heroin Other _____

ALCOHOL HISTORY

Do you drink alcohol? Yes Never drank Former drinker
How many glasses of wine per day? _____
How many glasses of beer per day? _____
How many hard spirits or shots per day? _____

SLEEP HISTORY

Do you currently have sleep issues? Falling asleep Staying asleep Easy waking None of these
Other (sleep walking, eating, night terrors, etc.) _____
How many hours of sleep on average do you get a night? _____ hours

TRAVEL HISTORY

List all recent travel outside of the country: _____

MEDICAL DEVICE HISTORY

Do You Use or Have Any of these Devices? Brace (Neck, Back) Pacemaker IUD Artificial Limbs
Artificial Heart Valve Blood Vessel Stent Joint Replacement Other Metal Implants: _____
Nexplanon (birth control implant)
Name + Serial Number (if available) _____

(continued)

Name: Date of Birth:

REVIEW OF SYSTEMS/HEALTH SCREENING HISTORY

Check the response that applies:

Y = current condition P = past condition N = a condition you've never had

GENERAL		When	
Weight		Height	
Weight 1 yr ago		Energy Level (1-10)	
Max Weight		General Daily Pain (1-10)	

CONSTITUTIONAL	Y	P	N
Chills			
Decline in Health			
Fatigue			
Fever			
Weight Gain			
Weight Loss			

HEAD	Y	P	N
Headache			
Head Injury			
Migraines			
Dizziness			

EYES	Y	P	N
Impaired Vision			
Eye Pain			
Tearing			
Dryness			
Glaucoma			
Cataracts			
Light Sensitivity			
Itchy Eyes			

EARS	Y	P	N
Impaired Hearing			
Ringing			
Earache			

NOSE/SINUSES	Y	P	N
Nose Bleeds			
Stuffiness			
Runny Nose			
Sinus Problems			

MOUTH/THROAT	Y	P	N
Frequent Sore Throat			
Gum Disease			
Hoarseness			
Teeth Grinding			
Canker Sores			

NECK	Y	P	N
Lumps			
Swollen Glands			
Goiter			
Pain or Stiffness			

RESPIRATORY	Y	P	N
Cough			
Spitting up Blood			
Wheezing			
Asthma			
Bronchitis			
Pneumonia			
Emphysema			
Pain on Breathing			
Shortness of Breath			
At Night			
Lying Down			

CARDIOVASCULAR	Y	P	N
Heart Disease			
High Blood Pressure			
Murmurs			
Chest Pain			
Swelling of Ankles			
Palpitations, Fluttering			

GASTROINTESTINAL	Y	P	N
Heartburn			
Easy fullness			
Nausea			
Vomiting			
Bowel Movements			
How Often?			
Is This a Change?			
Diarrhea			
Constipation			
Blood in Stool			
Belching or Gas			
Bloating			
Stomach Pain			
Jaundice (yellow skin)			
Liver Disease			
Hemorrhoids			

MUSCULOSKELETAL	Y	P	N
Joint Pain or Stiffness			
Arthritis			
Broken Bones			
Muscle Pain			
Muscle Spasms or Cramps			
Restless Legs			
Chronic Low Back Pain			
Motor Vehicle Accident			

BEHAVIORAL	Y	P	N
Bulimia			
Anorexia			
Addiction			
To What?			

EMOTIONAL	Y	P	N
Depression			
Anger			
Anxiety or Nervousness			
Trauma History			

SKIN	Y	P	N
Rashes			
Eczema			
Psoriasis			
Acne, Boils			
Itching			
Color Change			
Lumps			
Night Sweats			
Nails breaking			
Warts			
Fungal Infections			

NEUROLOGIC	Y	P	N
Fainting			
Seizures			
Paralysis			
Muscle Weakness			
Numbness or Tingling			
Loss of Memory			
Brain Fog			
Word Retrieval Problems			
Tremor			

ENDOCRINE	Y	P	N
Hypothyroid/Hyperthyroid			
Heat or Cold Intolerance			
Excessive Thirst			
Excessive Hunger			
Binge Eating			
Change in Libido			
Night Sweats			

BLOOD	Y	P	N
Anemia			
Bleeding			
Bruising			

IMMUNE SYSTEM	Y	P	N
Epstein Barr			
Mono			
Shingles			
CMV			
Lupus			
Crohn's			
Chronic Infections			
Lyme			

URINARY	Y	P	N
Pain with Urination			
Increased Frequency			
Inability to Hold Urine			
Frequent Infections			
Kidney Stones			

PERIPHERAL VASCULAR	Y	P	N
Deep Leg Pain			
Cold Hands/Feet			
Varicose Veins			

(continued)

FEMALE/MALE MEDICAL HISTORY — AND SEXUAL HISTORY

Name: Date of Birth:

Check the response that applies: Y = current condition P = past condition N = a condition you've never had

FEMALE MEDICAL HISTORY

MENTRUAL HEALTH			
Age Menses Began			
Average Number of Days			
Length of Cycle			
	Y	P	N
Bleeding Between Periods			
Regular Cycles			
Extended Time Without Menses			
How Long?			
Pain During Intercourse			
Vaginal Dryness			
Vaginal Itchiness			
Yeast Infections			
Painful Menses			
Bacterial Vaginosis			
Endometriosis			
PCOS (Polycystic Ovary Syndrome)			
Excessive Flow			
Excessive Facial Hair			
Excessive Body Hair			

MENOPAUSE	Y	P	N
Menopausal Symptoms			
Describe:			
Age They Began			
Age of Your Mother at Menopause			

BREAST HEALTH	Y	P	N
Do You Perform Self Exam			
Breast Lumps			
Breast Pain or Tenderness			
Nipple Discharge			

OBSTRETICS	Y	P	N
Birth Control			
What Type?			
Number of Pregnancies			
Number of Live Births			
Number of Miscarriages			
Number of Abortions			
Difficulty Conceiving			

MALE MEDICAL HISTORY

	Y	P	N
Hernias			
Testicular Masses			
Testicular Pain			
Prostate Problems			
Discharge or Sores			
Trouble Starting & Stopping Stream			
Erectile Disfunction			
Premature Ejaculation			
URINE RETENTION	**Y**	**P**	**N**
Scrotal Mass			
Scrotal Pain			

SEXUAL HISTORY

Gender Female Male Female-to-Male Male-to-Female Nonbinary Other

Sexual Orientation Identity
Bisexual Gay Heterosexual Lesbian Queer Not sure/Don't know Asexual Other

Are You Sexually Active? Yes No

Sexual Difficulties:

I have been diagnosed with and/or treated for:
Bacterial Vaginosis Chlamydia Gonorrhea Herpes HPV Syphilis Trich Other:

You have been tested for HIV in the past? Yes No

Are you HIV-positive? Yes No Unknown

You have ever been diagnosed with or tested for the following?
Hepatitis A Hepatitis B Hepatitis C

List additional health history which may be pertinent.

I certify that information supplied is correct to the best of my knowledge.

Printed Name _____ Date _____

Signature _____ Relationship to Patient: _____