TCSIG WELLNESS CENTER

Managed by Acorn Health Solutions
1174 Live Oak Blvd., Yuba City, CA 95991
Phone: 530-822-5500 Fax: 855-999-9261

PATIENT REGISTRATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): ☐ M ☐ F		DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Race/Ethnicity:		
Address: City: Zip:		
SSN:		Email address:
Mobile #:	Home:	Work:
TCSIG Medical Identification Number:		
Previous or referring doctor:		Date of last physical exam or physician visit:
Disabled: ☐ YES ☐ NO Do you have children and if so, how many: ☐ YES ☐ NO Number:		
Primary Pharmacy & Location:		

PERSONAL HEALTH HISTORY

Reason for your visit today
List any medical problems that other doctors have diagnosed or you are currently being treated for:
Major Surgeries Year Reason Hospital
Other hospitalizations
Year Reason Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?				☐ Yes ☐ No
	If yes, what kind?				
	Frequency:	Rarely	Occasionally	Moderately	Heavily
Tobacco	Do you use tobacco?				☐ Yes ☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?				☐ Yes ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation: