aspire2health P.A.

Phone 828-686-5232 www.aspire2health.com *Fax* 828-686-7712
2298 US 70 Hwy, Unit A Swannanoa, NC 28778

NEW PATIENT REGISTRATION

A VALID PHOTO ID AND INSURANCE CARD IS REQUIRED FOR PROCESSING.
SUBMIT IN PERSON OR BY MAIL (EMAIL NOT ACCEPTED).

Please fill all blanks. If not applicable, write N/A.

PATIENT INFORMATION

Today's Date:	**Last Name:**	**First Name:**
Preferred Name:	Middle Name:	Suffix:
Date of Birth:	**Legal Sex:** Male Female	Gender Identity:

Marital Status: Married Single Divorced Separated Widowed Partner	Emergency Contact:	
	Relationship:	Phone:

CONTACT INFORMATION

Address: [Street/PO Box, City, State, Zip]

Home Phone:	Mobile Phone: Same as Home? [ ]	Work Phone:

Email: No email? [ ]	**Contact Preference:** Home Phone Mobile Phone Work Phone Mail Portal

DEMOGRAPHIC INFORMATION (optional)

Language:	Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race:	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White

GUARANTOR INFORMATION (required for minors)

Last Name:	**First Name:**	**Date of Birth:**
SSN:	**Phone:**	Email:

Address: [Street/PO Box, City, State, Zip]
Same as Patient's above? [ ]

Please tell us how you heard about us:	Referred by?

Insurance cards received	Photo ID received	Patient approved	New Appointment Date ________________
All items completed		FOR OFFICE USE ONLY	New Appointment Time ________________

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Name: **Health History** DOB: / /

Present Complaint:	
Drug Allergies:	
List any Surgeries or Hospitalizations and Dates	List any Motor Vehicle Accidents and Dates

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS YOU ARE CURRENTLY TAKING

MEDICATION & MILLIGRAM	HOW OFTEN	PRESCRIBING PHYSICIAN	PHARMACY NAME

MAINTENANCE & PREVENTION: Check any procedure below and provide the date last completed.

☐ EKG	Date:	☐ Rectal Exam for Blood	Date:
☐ Chest X-Ray	Date:	☐ Colonoscopy	Date:
☐ Blood Panel	Date:	☐ Pneumonia Vaccine	Date:
☐ Cholesterol Level	Date:	☐ Tuberculin Skin Test	Date:
☐ Thyroid Profile	Date:	☐ Tetanus Booster	Date:
☐ Homocysteine Level	Date:	☐ Bone Density	Date:
☐ Flu Shot	Date:	☐ ______________________	Date:

Women's Health

Date of last menses	# of pregnancies
Date of last pap smear	# of births
Date of last breast exam	Menopausal Yes/No
Date of Last mammogram	Hysterectomy Yes/No

Circle any of the following menopausal symptoms:
Sleep disruption, Fatigue, Vaginal dryness,
hot flashes, irritability

Men's Health

Date of Last complete physical exam
Date of Last prostate exam
Date of Last PSA (blood test)
Are you taking Male Hormones? Yes or No
Any other health concerns?

Do You Exercise Regularly? Yes or No If yes, what types of activity? ____

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Name: **Social History** DOB: / /

Coffee ☐ No ☐ Yes, Amount	Tea ☐ No ☐ Yes, Amount	Tobacco ☐ No ☐ Yes packs per day	# of years
Caffeinated Soda ☐ No ☐ Yes, Amount	Any other drug history ☐ No ☐ Yes, explain		
Alcohol ☐ No ☐ Yes	Beer Amount per week	Wine Amount per week	Liquor Amount per week
Ever been convicted of a felony?			

Family Health History

MOTHER Living ☐ Age	Health Problems		
Deceased ☐ At age	Cause of death		
FATHER Living ☐ Age	Health Problems		
Deceased ☐ At age	Cause of death		
SISTERS	How many?	How many Living?	Ages?
General health among sisters			
BROTHERS	How many?	How many Living?	Ages?
General health among brothers			
MATERNAL GRANDMOTHER Living ☐ Age	Health Problems		
Deceased ☐ At age	Cause of death		
MATERNAL GRANDFATHER Living ☐ Age	Health Problems		
Deceased ☐ At age	Cause of death		
PATERNAL GRANDMOTHER Living ☐ Age	Health Problems		
Deceased ☐ At age	Cause of death		
PATERNAL GRANDFATHER Living ☐ Age	Health Problems		
Deceased ☐ At age	Cause of death		
FAMILY HEALTH HISTORY NOT KNOWN ☐			