RaphaHealth
Good Health. Long Life.

4/F Greenbelt 5, Ayala Center Makati City

PATIENT REGISTRATION FORM
(Please write legibly)

Name _____Birth date _____
LASTNAME **FIRST NAME** **MIDDLE NAME**

Age _____ Sex _____ Civil Status _____ Religion _____

Metro Manila Address _____

_____

Permanent Address _____

_____

Landline _____ Mobile No. _____

Personal Email _____ Work Email _____

Occupation _____

Company _____

Address _____

_____

Person to call in case of emergency _____

Relationship _____ Contact Number _____

I hereby certify that the information are true and correct and hereby give my permission to administer treatment and perform such procedure as maybe deemed necessary by Rapha Health physician.

_____ _____
Signature over printed name Date

Important:

Each patient is responsible for payment at time of service. If you have any question concerning fees for services, please ask the office manager prior to receiving examination and treatment. You may referred for additional testing. Please be aware that you are responsible for your account at the referred office as well.

How did you know Rapha Health? _____

MEDICAL HISTORY

Please answer truthfully

Number of children & Age/s _____

Do you smoke? _____ How often/much? _____

Do you drink? _____ How often/much? _____

Personal Medical History

Please check known Disease/s you have been diagnosed with:

☐ Diabetes ☐ Hypertension ☐ Highest BP _____ Usual BP _____ ☐ High cholesterol ☐ Hypo/Hyperthyroidism ☐ Stroke ☐ Cancer Type _____ ☐ Heart Disease Type _____ ☐ Rheumatic Fever ☐ Gout/high uric Acid ☐ Arthritis ☐ Frequent cough & Colds ☐ Asthma	☐ Emphysema ☐ Tuberculosis ☐ UTI ☐ Kidney disease ☐ GERD ☐ Stomach/Peptic ulcer ☐ Colitis ☐ Liver disease ☐ Jaundice ☐ Hepatitis ☐ Epilepsy ☐ Cataract/Glaucoma ☐ HIV/AIDS/STD ☐ Psoriasis ☐ other autoimmune disease

Name the medications you are taking for what reasons:

_____

_____

_____

_____

Have you ever been hospitalized? _____ If yes, for what?

_____

_____

FOR WOMEN	**FOR MEN**
Date of Last Menstruation _____	Enlarged prostate _____
Regular? Yes/No	Erection problem _____
Menopause _____	Loss of libido or interest in sex _____
Loss of sexual desire _____	Lack of orgasm _____
Night sweat _____	Premature ejaculation _____
Hot flushes _____	Difficulty in penetration _____
Painful menstruation _____	
Vaginal dryness _____	
Painful sexual intercourse _____	
Lack of orgasm _____	
Problem during pregnancy _____	

Please place a check in the appropriate space

REMARKS

- ☐ Allergy _____
- ☐ Blindness or blurring of vision _____
- ☐ Brittle or falling hair _____
- ☐ Chest pain or pressure _____
- ☐ Cold / heat intolerance _____
- ☐ Confusion or indecisiveness _____
- ☐ Constipation _____
- ☐ Difficulty falling asleep _____
- ☐ Dizziness _____
- ☐ Easily fatigued/sluggish _____
- ☐ Excessive sweating _____
- ☐ Frequent urination at night _____
- ☐ Headaches _____
- ☐ Anxiety or depression _____
- ☐ Memory loss or lapses _____
- ☐ Muscle, joint or back pain _____
- ☐ Pain upon walking _____
- ☐ Shortness of breath _____
- ☐ Stomach or bowel problems _____
- ☐ Stress at work or home _____
- ☐ Weakness of arms & / or legs _____
- ☐ Weight gain / loss _____