BEATRIZ R. OLSON MD, FACP
REGISTRATION FORM

(Please Print)

Today's date:				
PATIENT INFORMATION				
Patient's last name: First: Middle:				Sex: ❑ M ❑ F
Birth date: / /	Age:	Marital status (circle one) Single / Mar / Div / Sep / Wid	Do you have children? ❑ Yes ❑ No	If yes, how many?
Street address:		Mobile phone no.:		Home phone no.:
City:		State:		ZIP Code:
E-mail:		Occupation:		Employer:
Reason for seeing Dr. Olson:			Referred to us by:	
Primary Care Physician (Name and Phone No.):		Gynecologist (Name and Phone No.):		

INSURANCE INFORMATION		
We do not participate with any commercial insurance, Medicare, Medicaid, or Husky plans. However, as a service to you, we will submit our invoice to your insurance company so that you may receive whatever reimbursement you are entitled to for out-of-network providers.		
Name of Insurance	Policy Number	Group #
Subscriber's Name	Patient's relationship to subscriber:	Address (if different):
(Please provide your insurance card along with this form when you are finished)		

EMERGENCY CONTACT / SIGNATURE		
Full name:	Relationship to patient:	Phone no.:
The above information is true to the best of my knowledge. I understand that Dr. Olson does not participate with any commercial insurance, Medicare, Medicaid, or Husky plans. Payment is expected at the time of the office visit by cash or credit card.		
Patient/Guardian signature		*Date*

MEDICAL INFORMATION AND HISTORY	
List all current medications and doses as well as supplements and vitamins below:	
Date of last mammogram: Date of last colonoscopy:	Date of last pap smear: Date of last eye exam:
Do you wear a medical bracelet? What for?	
List all allergies to medications/allergens and your reaction to them:	
List all medical/psychological problems you currently have or are being treated for now:	
List past surgeries and hospitalizations (include dates):	

FAMILY HISTORY: INCLUDE WHO IS AFFECTED (PARENTS, SIBLINGS, CHILDREN)	
How many siblings do you have? How many are alive?	Are your parents alive? Mother (yes / no) Father (yes / no)
Heart disease or early deaths?	Excess hair, or infertility or polycystic ovary?
Breast cancer?	Auto-immune diseases?
Diabetes?	Thyroid problems?
Osteoporosis?	Obesity?
Pituitary tumors?	Psychiatric problems?
Calcium problems or kidney stones?	Alcohol or drug abuse?
High blood pressure?	List types of Cancers your family has had:
Adrenal tumors or growth?	

REVIEW OF SYSTEMS	
Do you sleep well? Do you wake up rested? Do you snore? Do you have sleep apnea? Do you have asthma?	What is your highest weight? What is your lowest adult weight? Are you a sedentary or fairly active person? Do you exercise regularly? What is your favorite way to exercise?
If you don't sleep well, what keeps you from sleeping? Do you have energy to do what you need to do? Have you had periods bedridden?	Do you smoke? If yes at any point, how many years? How many alcoholic drinks per week do you have? Do you use marijuana?
Are you happy with your diet? How many meals do you have per day? List your most frequent 5 foods:	High blood pressure? Do you have a cholesterol or lipid problem? Do you have heart disease/heart attack? Do you have pre-diabetes or diabetes? Women: Did you have diabetes when pregnant?
Do you drink milk now? Did you drink milk as a child? Have you had vitamin D deficiency?	Have you had fractures? If yes where? Are you a vegetarian? For how long?
Have you been treated with steroids for extended periods of time?	Do you have osteoporosis?
Do you have osteopenia? If yes spine, hip or both?	What treatments have you received for osteopenia or osteoporosis?

CARBOHYDRATE / METABOLISM / DIABETES	
Recent weight loss or weight gain? How many pounds? Has the weight change been gradual or fast and recent?	Do you sweat after you eat or after alcohol? Do you have flushing episodes? How often?
If you have diabetes, is there damage to your: Eyes, kidneys, or nerves?	Increased thirst and or increased urination lately?
Is your weight in the abdomen or hip and thighs or generalized?	Are you waking up at night multiple times to urinate?
Digestion problems, ulcers, reflux:	Have you passed out after exercising or after not eating for a while?
New problems with your eyes or vision? Do you have dry eyes or dry mouth? Difficulty Swallowing?	Do you have a diagnosis of low blood sugar? Do you have times when your heart beats very fast and you get sweaty?
Do you have irritable bowel?	Do you have Celiac Disease?
Do you have inflammatory bowel disease?	Do you have seizures?

THYROID	
Do you have difficulty swallowing? Have you had neck surgery? Has the sound of your voice or singing changed?	Do you have a thyroid problem: Goiter or lumps or nodules, or cancer? How long have you known this? Did you have thyroid biopsies? If so where?
Do you feel warmer or colder than most?	Do you experience constipation / diarrhea?

How is your energy? Normal, low, high?	Are you experiencing tremors?
Have you lost hair recently?	Are you anxious and/or moody? All the time or recently or pre-menstrually?
Have your skin or nails changed lately?	Does your heart beat fast and forcefully (palpitations)?
Have you ever received radiation to your head, neck or tonsils? Have you ever been exposed to industrial chemicals or radiation?	If you have thyroid cancer: When was your thyroid removed? Did you receive radioactive iodine?

HYPOTHALAMUS/PITUITARY/ADRENAL	
Are you very tearful or depressed lately?	Do you have new stretch marks in your body?
Do you bruise easily?	Do you have new muscle weakness?
Have you developed acne or excess hair recently?	Have you had an accident or fall where you lost consciousness or had a traumatic brain injury?

ADRENAL INSUFFICIENCY	
Do you feel fatigued and tired all the time? What is tired: Your body, mind, both?	Is your skin darker than it used to be? What do you do to increase your energy?
Do you crave salty foods all the time? Do you have more, same, or less appetite than usual?	Are you light headed when you stand up?
Do you have anemia?	Have you had mono or a tick disease in the past?

GROWTH HORMONES	
Do you have new headaches?	Do you have more body odor than usual?
Has your hat, ring, or shoe size increased?	Problems with your teeth or bite or deepening of your voice?
Arthritis and/or carpal tunnel syndrome?	Any new problems with your vision?

GENERAL ENDOCRINE	
Do you have fluid discharge from your nipples?	Are there any endocrine issues that have not been mentioned that affect you?
Do people in your family have a problem with too much iron?	

MEN ONLY	
Are you shaving less than usual?	Has your interest in sex changed lately?
Do you have normal erection and ejaculation during intercourse?	Do you have new breast tissue?
Do you have morning erections?	Do you have prostate problems?

WOMEN ONLY	
Are you pregnant? Last period date?	Do you or did you have difficulty getting pregnant?
How old were you at your first period or menstruation?	Do you have breast tenderness and other premenstrual symptoms before your period?
Are your periods every month or irregular? Is this new?	Do you have polycystic ovary syndrome?
Are you in menopause? Age when periods stopped? Did or do you use hormone replacement?	Did you have a hysterectomy? Have you had your ovaries removed? If yes, one or both?
Do you have night-sweats, hot flushes and/or vaginal dryness?	Are you sexually satisfied with your partner?
Do you have an eating problem such as bulimia, bingeing, night snacking?	Has your interest in sex changed lately?

FOR EVERYONE	
Do you like your job?	What are your 2 highest personal values?
Do you like your spouse?	What is your way to de-stress?
Do you have and live in a supportive environment?	Are you in counseling now or have you been in the past?
Have you ever been raped or sexually molested?	Do you see a chiropractor or naturopathic physician?
Did you experience major stresses in your life that affect you now? Are you intimate physically with your spouse/partner?	Are you taking homeopathic treatments now?

ANYTHING ELSE?
Is there anything else you need for me to know?