Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Wellness Exam/Physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any hospitalizations and dates: ***\*Continue list on back if needed.\****

Date Reason Date Reason

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Current Health Problems** | Date of Onset |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

***\*Continue list on back if needed.\****

|  |  |
| --- | --- |
| **Surgical History –** ex. Knee replacement | Date of Surgery |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

***\*Continue list on back if needed.\****

|  |  |  |
| --- | --- | --- |
| **CURRENT MEDICATIONS (**Include vitamins and over the counter medications) | **DOSAGE** | **HOW MANY TIMES PER DAY** |
| *EX: Aspirin* | *81 mg* | *Once a day* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***\*Continue list on back if needed.\****

Are you **allergic** to any **medications?** Yes No If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Environmental/Food allergies?** Yes No If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a living will or advanced directives? Yes No If yes, please provide a copy to our office

**FAMILY HISTORY *\*Continue list on back if needed.\****

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Relative*** | ***Age*** | ***Medical Conditions*** | ***Age of Death*** | ***Cause of Death*** |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Sibling |  |  |  |  |
| Sibling |  |  |  |  |
| Child |  |  |  |  |
| Child |  |  |  |  |

Do you **Smoke?** Yes No If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever **Smoke?** Yes No If yes, when did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you **Drink Alcohol?** Yes No If yes, how many drinks a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever **Drink Alcohol?** Yes No If yes, when did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following tests performed:**

Colonoscopy Yes      No               If Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap Smear Yes      No               If Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram Yes      No               If Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Density Scan Yes      No               If Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia Vaccine Yes      No               If Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus Booster Yes      No               If Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER PHYSICIANS:**

**OB/GYN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEURO:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDIOLOGIST:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PULMONOLOGIST:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ORTHOPEDIC:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_