Family Health and Wellness Center

Name _____Reason to be seen today?_____

Primary Care Physician _____ Pain Management Physician_____

Married___ Divorced ____ Single ___ Widowed_____

Employed____ Unemployed____ Occupation_____How many children do you have _____

Are you being seen by any other specialist? **Yes/No** If so, Who?_____

Do you have an Advanced Directive or Living Will?_____ If no would you like a form?_____

1. Are you allergic to any medications? _____ If so, which ones and what reaction occurs?

   _____

2. What pharmacy do you use? _____ Phone Number _____
3. Do you use tobacco products? _____ What kind? _____ How many? _____

   If you smoked in the past, when did you quit?_____
4. Do you drink alcoholic beverages? _____ If so, which ones and how much per day?_____ and week? _____

   Do you use any drugs? _____ Have you in the past? _____ If so, what kind? _____When did you last use? _____

   Do you exercise?_____ How often_____
5. Date of last:

   Colonoscopy _____
   Eye Exam _____
   Flu Shot_____ Pneumonia shot_____

   Women Only:

   Last Menstrual Period _____
   Pap Smear _____
   Mammogram _____

6.

Past Medical Hospitalizations		**Past Surgery:**	
Date	*Reason*	*Date*	*Reason*

MEDICATIONS	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

7. **Family History**
   Please check if a blood related member of your family has had any of the following and Which member has it:

☐ TB	☐ Heart Disease	☐ Bleeding Tendency	☐ Rheumatic Fever
☐ High Blood Pressure	☐ Anemia	☐ Diabetes	☐ Strokes
☐ Arthritis	☐ Cancer	☐ Thyroid Disease	☐ Lung Disease
☐ Mental Disease	☐ Glaucoma	☐ Kidney Disease	

☐ Other Disease: _____

8. **Medical Problems:** Do you have, or have you ever had, any of the following?

☐ Alcohol or Drug Addiction	☐ Diabetes	☐ Lung Disease
☐ Asthma	☐ Ear, Nose, or Throat Problems	☐ Neurological problems
☐ Bladder problems	☐ Hepatitis or liver disease	☐ Psychiatric problems
☐ Bleeding disorder	☐ High blood pressure	☐ Skin disease
☐ Bowel disease	☐ Heart disease	☐ Thyroid disease
☐ Cancer	☐ HIV/AIDS	☐ Ulcers or stomach problems
☐ Circulation problems	☐ Kidney disease	☐ Other medical conditions

If you answered yes to any of the above, please describe: _____
_____
_____

9. Other things about your health you wish the doctor to know: _____
   _____
10. List any chronic diseases you have: _____
    _____
11. Signature of person completing this form: _____ Date: _____
12. Who may we communicate with regarding your condition or course of treatment?_____
    _

March 2015

Date ____/____/_____

Patient Information:

LAST FIRST MIDDLE INTIAL			DOB	M/F	RACE
HOME ADDRESS	CITY	ZIP	HOME TELEPHONE		
CELL NUMBER	EMAIL	SSN	DL NUMBER		
PRIMARY INSURANCE POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE			
CARDHOLDERS NAME	CARDHOLDERS DOB	CARDHOLDER'S PHONE NUMBER	RELATIONSHIP		
SECONDARY INSURANCE POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE			
CARDHOLDERS NAME	CARDHOLDERS DOB	CARDHOLDER'S PHONE NUMBER	RELATIONSHIP		

How would you like to receive notification from our office (check following)?

____Mobile text notification
____Call Notification
____E-mail notification

Emergency Contact:

LAST	FIRST	RELATIONSHIP	PHONE NUMBER

Financial Guarantor (if patient is a minor):

LAST	FIRST	DOB	PHONE NUMBER
RELATIONSHIP	ADDRESS		