A Family Wellness Center
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Patient Information

Date ______________

Patient Name ____
Last Name First Name Middle Name

Sex ☐ Male ☐ Female Date of Birth ______________ Age ________ SS# ______________

Street Address ____ Apt. __________

City ______________________ State ______________________ ZIP ______________

Home Phone ______________________ Work Phone ______________________ Other ______________

☐ Single ☐ Married ☐ Partner for ______ years ☐ Separated ☐ Divorced ☐ Widowed

☐ Student ☐ Not Employed ☐ Employed Part Time ☐ Employed Full Time ☐ Retired

Occupation ______________________ Employer/ School ______________________

Address ____

Education ____

How did you hear about us ____

Spouse/ Parent/ Guardian/ or Significant Other ______________________________

Work Phone ______________________ Home Phone ______________________

Person to Contact in Case of Emergency ______________________________

Work Phone ______________________ Home Phone ______________________

Health History Questionnaire

Holistic health care and preventative medicine are only possible when the physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

When and where did you last receive medical or health care? ______________________________

____

What was the reason? ____

____

What are your most important health problems?

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Family History: *Check those applicable*

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health G= good P= poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hay fever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age (at death)						
Cause of death						

Personal History:
For the following sections, please circle Y = yes or N = no

Childhood Illnesses:

Scarlet fever	Y	N	Diphtheria	Y	N	Rheumatic Fever	Y	N
Mumps	Y	N	Measles	Y	N	German Measles	Y	N

Other___________________________

Hospitalization and Surgery: Please list with dates ____

____

____

X-rays, CAT scans, or MRI's: Please list with dates ____

____

____

Electrocardiogram Y N Electroencephalogram Y N

Immunizations						
	Polio	Y	N	Pertussis	Y	N
	Tetanus shot (not antitoxin)	Y	N	Diphtheria	Y	N
	Measles/Mumps/Rubella	Y	N	Other ___________________		

Allergies: Please list any foods, drugs or other allergens: ____

____

____

____

Current medications: Please list prescription medications, over-the-counter medications, vitamins or other supplements you are taking:____

____

____

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Sleeping pills	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N			

Review of Systems

Please circle one: Y = a current condition, P = a past condition, leave blank for never had.

General

Weight ________ Weight 1 year ago______ Max weight ____________ When ___________

Height ________ Fatigue Y P

Skin

Acne	Y	P	Itching	Y	P	Night sweats	Y	P
Color change	Y	P	Lumps	Y	P	Rashes	Y	P
Eczema, Hives	Y	P						

Head

Headache	Y	P	Head injury	Y	P

Eyes

Impaired vision	Y	P	Glasses or contacts	Y	P
Eye Pain	Y	P	Tearing or dryness	Y	P
Double vision	Y	P	Glaucoma	Y	P
Cataracts	Y	P			

Ears

Impaired hearing	Y	P	Ringing	Y	P
Earache	Y	P	Dizziness	Y	P

Nose and Sinuses

Frequent colds	Y	P	Nose bleeds	Y	P
Stuffiness	Y	P	Hay fever	Y	P
Sinus problems	Y	P			

Mouth and Throat

Frequent sore throat	Y	P	Sore tongue	Y	P
Gum problems	Y	P	Hoarseness	Y	P
Dental cavities	Y	P			

Neck

Lumps	Y	P	Swollen glands	Y	P
Goiter	Y	P	Pain or stiffness	Y	P

Respiratory

Cough	Y	P	Spitting up blood	Y	P
Sputum	Y	P	Wheezing	Y	P
Asthma	Y	P	Bronchitis	Y	P
Pneumonia	Y	P	Emphysema	Y	P
Pleurisy	Y	P	Difficulty breathing	Y	P
Pain on breathing	Y	P	Tuberculosis	Y	P
Shortness of breath	Y	P	Short/breath lying down	Y	P
Short/breath at night	Y	P			

Cardiovascular

Heart disease	Y	P	Angina	Y	P
High blood pressure	Y	P	Murmurs	Y	P
Palpitations, fluttering	Y	P	Rheumatic fever	Y	P
Swelling in ankles	Y	P	Chest pain	Y	P

Gastrointestinal

Trouble swallowing	Y	P	Heartburn	Y	P

Change in thirst	Y P	Change in appetite	Y P
Nausea	Y P	Vomiting	Y P
Vomiting blood	Y P	Belching, passing gas	Y P

Bowel movements How often? ______________ Is this a change? Y N

Blood in stool	Y P	Hemorrhoids	Y P
Jaundice (yellow skin)	Y P	Liver disease	Y P
Gall bladder disease	Y P	Ulcer	Y P

Urinary

Pain on urination	Y P	Increased frequency	Y P
Frequency at night	Y P	Inability to hold urine	Y P
Frequent infections	Y P	Kidney stones	Y P

Female Reproductive

Regular cycles	Y P	Painful menses	Y P ________
Length of cycle	_______	Menopausal symptoms	Y P
Average number of days	_______	Are you sexually active?	Y P
Number of pregnancies	_______	Pain during intercourse	Y P
Number of live births	_______	Difficulty conceiving	Y P
Number of miscarriages	_______	Venereal disease	Y P
Number of abortions	_______	Sexual difficulties	Y P
Excessive flow	Y P	Birth control	Y P
Bleeding between periods	Y P	What type of birth control	___________

Sexual preference: Heterosexual ____ Bisexual ____ Homosexual ____

Breasts

Do you do self exams?	Y P	Lumps	Y P
Pain or tenderness	Y P	Nipple discharge	Y P

Male Reproductive

Hernias	Y P	Pain during intercourse	Y P
Discharge or sores	Y P	Difficulty conceiving	Y P
Testicular pain	Y P	Venereal disease	Y P
Are you sexually active?	Y P	Sexual difficulties	Y P

Sexual preference: Heterosexual ____ Bisexual ____ Homosexual ____

Muscoskeletal

Joint or pain stiffness	Y P	Arthritis	Y P
Broken bones	Y P	Weakness	Y P
Muscle spasms / cramps	Y P		

Peripheral Vascular

Deep leg pain	Y P	Cold hands or feet	Y P
Varicose veins	Y P	Thrombophlebitis	Y P

Neurological

Fainting	Y P	Seizure	Y P
Paralysis	Y P	Muscle weakness	Y P
Loss of memory	Y P	Numbness	Y P

Emotional

Depression	Y P	Anxiety or nervousness	Y P
Mood swings	Y P	Tension	Y P

Endocrine

Hypothyroid	Y P	Heat or cold intolerance	Y P
Excessive thirst	Y P	Excessive hunger	Y P

Blood

Anemia	Y P	Easy bleeding	Y P

What are you main interests and hobbies? ______________________________

____

Do you exercise? Y N What forms? ______________________________
How often? ______________________________

Do you eat three meals daily	Y N	Awaken rested	Y N
Average 6-8 hours sleep	Y N	Sleep well	Y N
Enjoy your work	Y N	Spend time outside	Y N
Watch television	Y N	How many hours/day (TV)	________
Read	Y N	How many hours/day (Read)	________
Take vacations	Y N	Use tobacco	Y N
Use recreational drugs	Y N	Been treated for drug dependence	Y N
Use alcoholic beverages	Y N	Been treated for alcoholism	Y N

Primary Insurance: (please refer to the financial policy for insurance information)

Insurance Company ______________________ Telephone # ______________________

Address ______________________________

ID# ______________________ Policy ______________________

Group # ______________________ Group Name ______________________

Name of Insured ______________________ Relationship to insured ______________________

Address ______________________________

How much is your deductible? ____________ How much is your copay? ____________

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits to A Family Wellness Center for services rendered.

______________________________ ______________________
Patient's or Authorized Person's Signature **Date**