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**