

The Wellness Point

PATIENT INFORMATION FORM

Name:	Birth date:	SS#:
Address:	Phone Numbers Home:	Primary Care Provider:
	Work:	Referring Physician:
Reason for Visit:	Date of Onset:	Allergies: <input type="checkbox"/> None

Emergency Contact: _____ Phone: _____ Relationship: _____
 Height: _____ Weight: _____
 Are you pregnant? Y N
 Do you have a pacemaker? Y N
 Are you taking any blood thinners? Y N If yes, which medications? _____

Past Medical History (Check all that apply; Explain as necessary)

- | | |
|--|---|
| <input type="checkbox"/> Cancers _____ | <input type="checkbox"/> Headaches _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Bowel Problems _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Gynecological Problems _____ |
| <input type="checkbox"/> Diabetes _____ | |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Anxiety _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma _____ | |

Surgeries (Please list with dates): _____

Medications (Including vitamins, supplements, herbal therapies, over-the-counter medications, etc.)

_____	_____
_____	_____
_____	_____

Habits (Please include type, amount, and frequency)

- | | |
|--|--|
| <input type="checkbox"/> Tobacco _____ | <input type="checkbox"/> Other Drugs _____ |
| <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Caffeine _____ |

Please describe your diet: _____

How often do you exercise? _____

Please describe your typical physical activity or exercise: _____

Family History (Please indicate which relative)

- | | |
|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Addiction _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Allergies/Asthma _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stroke _____ | |

How did you hear about The Wellness Point? _____

