

The Wellness Point

PATIENT INFORMATION FORM

Name:	Birth date:	Email:
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? _____ 