Welcome to Wayland Personal Physicians

Please complete all **3** pages.

PATIENT NAME: _____ Email: _____

PRESENT HEALTH CONCERNS:

_____
_____
_____

PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

___Congenital Heart Disease
specify type:_____
___Ulcer (stomach/intestine)
___Cancer
___Heart attack
___High blood pressure
___Diabetes
___High cholesterol
___Coagulation (bleeding/clotting) disorder
___Thyroid problem
specify type:_____
___Heartburn
___Emphysema
___Depression
___Alcoholism
___History of blood transfusion
___Stroke
___Asthma
___Other problems:
_____
_____
_____
_____

MEDICATIONS: Prescription and non-prescription medications, vitamins, birth control pills, herbs:

Medication, Supplement, Vitamin	Dose	TImes/ Day	Medication, Supplement, Vitamin	Dose	Times /Day

ALLERGIES to Medications, Foods or Other Agents:

Medication	Reaction or Side Effect

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SURGICAL HISTORY (please list all prior surgeries and dates):

Operation	Date	Operation	Date

FAMILY HISTORY:

Medical Condition	Mom	Dad	Bro.	Sis.	child	other	other	Medical Condition	Mom	Dad	Bro.	Sis.	child	other	other
Alcoholism								Other cancer							
Anemia								Glaucoma							
Anesthesia issue								Seasonal allergies							
Rheumatoid Arthritis								Hearing problems							
Asthma								Heart attack							
Birth defects								High blood pressure							
Bleeding problem								High cholesterol							
Breast Cancer								Kidney disease							
Colon cancer								Lupus							
Skin cancer								Migraine headaches							
Melanoma								Osteoarthritis							
Ovarian cancer								Osteoporosis							
Prostate cancer								Stroke							
Depression								Thyroid disorders							
Type I diabetes								Eczema							
Type II diabetes								Epilepsy (seizures)							

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SOCIAL HISTORY:

Occupation:_____ Marital status:_____ Number of children:_____

Who lives at home with you?_____

Do you use seatbelts consistently?_____ Do you use a bike helmet regularly?_____

Is violence at home a concern for you?_____ Do you feel safe in your current relationship?_____

Do you have a gun in your home?_____

How frequently do you use sunscreen? _____

Are you a cigarette smoker?_____ If so, are you interested in quitting? ____

Have you ever been a smoker?_____ If so, how many packs/day?_____ # of years _____ Year quit: _____

How many drinks of alcohol per week?_____ Is your alcohol use a concern for you or others?_____

Do you use marijuana? ___ If so, how frequently? _____

Do you use any other recreational drugs?_____ Have you ever used IV drugs?_____

Do you exercise regularly?_____ If so, what exercise and how often?_____

During the past month, have you often:

1. Felt little interest or pleasure in doing things? ___yes ___no
2. Felt down, depressed or hopeless? ___yes ___no

SEXUAL HISTORY:

Are you sexually active? ___yes ___no ___not currently Sexual partner(s) is/are: ___ male ___ female ___ both

Birth control method:_____ or ___none needed

If sexually active, do you practice safe sex? ___yes ___no Have you ever had a sexually transmitted disease? ___yes ___no

WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies:____ # deliveries:____ # abortions:____ # miscarriages:____

Age at first period:_____ Date of last pap smear:_____ Any abnormal pap smears in the past?_____ Last period? _____

SCREENING**:**

Date of most recent:

Colonoscopy: _____ Normal? ___ yes ___no

Mammogram: _____ Normal? ___yes ___no

Eye Exam: _____ Normal? ___yes ___no

Bone density test: _____ Normal? ___yes ___no

Which is your preferred pharmacy? _____ City/Town: _____

Who is your Health Care Proxy? _____ Phone: _____ Relation: _____