

WeCare Comprehensive Family Medicine, LLC

PLEASE FULLY COMPLETE THIS FORM: Your answers will help your provider understand your medical concerns and conditions better.

NAME: _____ AGE: _____ DATE OF BIRTH: _____

REASON FOR TODAY'S VISIT: _____

ALLERGIES and/or REACTIONS TO MEDICINES: _____

CURRENT MEDICATIONS: Prescription, non-prescription medicines, vitamins, and supplements.

Medication	Dose (e.g. Mg/pill)	How many times/day	When started

PERSONAL MEDICAL HISTORY: Do you or have you had any of these problems? For yes answers give further details below.

YES/DATE	MEDICAL PROBLEM	YES/DATE	MEDICAL PROBLEM
	Irregular Heart Beat		Kidney Stones
	Congestive heart Failure		Kidney Disease/Infections
	Blood Clot		Breast Disease
	High Cholesterol		Fracture, which bone(s): _____
	High Blood Pressure		Arthritis
	Heart Attack		Gout
	Heart Murmur		Stroke
	Asthma		Dementia
	Skin disease, Type: _____		Cancer, Type: _____
	Pneumonia		HIV
	Pulmonary Embolism		STDs
	Tuberculosis		Blood Transfusion
	Sleep Apnea		Anemia
	Gall Stones		Bleeding Disorder
	Liver Disease/Hepatitis		Seasonal Allergies
	Hemorrhoids		Emphysema/Chronic Bronchitis
	Diabetes Type 1 (Childhood onset)		Stomach Ulcer
	Diabetes Type 2 (Adult onset)		Problems During Pregnancy
	Diverticulitis		Thyroid Disease (High/Low)
	Ulcerative Colitis/ Crohn's		Depression
	Heart Burn/ Reflux		Anxiety

Further explanation for "yes" answers: _____

LIST ANY HOSPITALIZATIONS: (reason and date): _____

WOMEN'S GYNOLOGICAL HISTORY: Sexually active: Yes / No Contraceptive Method: _____

Date of First Period: _____ Date of last Period: _____

of Pregnancies _____ # of Deliveries _____ # of Miscarriages _____ # of Abortions _____ Menopausal: No / Yes Date _____

Last PAP smear _____ Abnormal PAP smear: Yes / No

Last mammogram _____ Abnormal mammogram: Yes / No

HEALTH MAINTENANCE: When were your most recent screening tests?

Cholesterol Screening? _____ Results? _____ PSA (Prostate cancer screen)? _____ Results? _____

Sigmoidoscopy? _____ Results? _____ Stool Test for Blood? _____ Results? _____

IMMUNIZATIONS: Please indicate the date of your most recent: Tetanus _____ Pneumovax (Pneumonia) _____

SOCIAL HISTORY: Tobacco Use: Cigarettes _____ Never _____ Quit: Date _____ Current Smoker: packs/day _____ # of years: _____

Other Tobacco: Pipe _____ Cigar _____ Chew _____ Interested in quitting? Yes / No

Alcohol Use: Do you drink alcohol? No / Yes, # of drinks/ week _____ Is alcohol use a concern for you or others? No / Yes

Illicit Drug use? No / Yes, Name/s of Drugs _____

SOCIOECONOMICS: Marital Status: S M D W Other: _____ Spouse/Partner's name: _____

Children: Names and Ages _____

Occupation: _____ Employer: _____ Years of Education/ Highest Degree: _____

SEXUAL ACTIVITY: Sexually Active: Yes / No / Not Currently Current sex partner(s) is/are: Male _____ Female _____

EXERCISE: Do you exercise regularly? No / Yes, What kind of Exercise? _____

How long? (minutes) _____ How often? _____

SURGICAL HISTORY: Have you had any of these surgeries? Please use space below for further information if needed.

