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 GYNOCOLOGICAL 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.

Yes/Date	Surgery		Yes/Date	Surgery
	Appendectomy			Gallbladder
	Joint Arthroscopy, Joint:			Joint Replacement, Joint:
	Heart Catheterization			Back Surgery
	Abdominal Surgery			Prostate
	Neck Artery			Vasectomy
	Open Heart/ Bypass			Tonsillectomy
	Hemia			Adenoidectomy
	Biopsy (of what?)			Cosmetic
	Broken Bone Repair			C-Section
	Sinus			Hysterectomy: Vaginal / Abdominal
	Lasik R or L			Ovaries out? Yes / No
	Cataract R or L			Other:
	Other:			Other:

FAMILY HISTORY: Please indicate with a check family members who have had any of the following conditions:

Medical condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Mom's mom	Mom's dad	Dad's mom	Dad's dad	Mom's sister	Mom's bro	Dad's sister	Dad's bro
Alcoholism														
Anemia														
Anesthesia problem														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problem														
Cancer, breast														
Cancer, colon														
Cancer, melanoma														
Cancer, ovary														
Cancer, prostate														
Heart attack (coronary artery disease)														
Birth defects														
Depression														
Diabetes, type 1 (childhood onset)														
Diabetes, type 2 (adult onset)														
Eczema														
Food Allergies														
Other genetic disease														
Hay fever														
Hearing problems														
High cholesterol (Hyperlipidemia)														
High blood pressure (Hypertension)														
Immunosuppressive disorders														
Kidney disease														
Mental Retardation														
Osteoporosis														
Epilepsy (seizure disorder)														
Stroke														
Substance abuse														
Thyroid disorders														
Smoking														
Tuberculosis														
Other:														
Other:														