BW PRIMARYCARE
Bridge to Wellness

Patient History Form, age 5-11

Name_____

Date of Birth_____ M or F

Current **grade** level _____

Parent/Guardian(s)

_____

_____

Prior Primary Care Provider or other specialists seen within past 2 years

_____

_____

Allergies or reactions to medications?

_____

Has the child been hospitalized for **illness** or **surgery**? Provide dates as well.

_____

_____

Recent changes in family, living or school situation?

_____

_____

Are you concerned about the child's mental health or abilities in school? _____**If the above answer is yes, please fill out a mental health questionnaire- ask a staff member**

Problems or concerns with any of the following, either in the child or a family member?

Heart

_____

Lungs

_____

Head/ears/nose/throat

Abdomen/Stomach/Intestines

Muscles or Joints

Nervous system

Depression or Anxiety

High blood pressure

High cholesterol

Diabetes

Thyroid disease

Cancer

Skin

Other

Family History **Medical Problems**

Mother

Father

Brothers/Sisters

Other Health History

Is there a smoker in the home?

Last dental appointment?

Last vision screen or eye doctor appointment?

Is there a family or household contact with **HIV, tuberculosis, Hepatitis C or any other infectious disease of concern?**

Are there any specific concerns you would like to address at this first appointment?

List **current medications**, with dose and frequency, and any other vitamins and/or supplements taken by the child

Do you have a copy of the **child's immunization record**? _____If so, please bring to the appointment. If not, please ask us to make you a copy, or obtain from your prior provider.

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Bridge to Wellness

Patient History Form, age 12-21

Name_____

Date of Birth_____ M or F

Current school/grade level _____

Current job situation

_____

Parent/Guardian(s)

_____

_____

Prior Primary Care Provider or other specialists seen within past 2 years

_____

_____

Allergies or reactions to medications?

_____

Has the patient been hospitalized for **illness** or **surgery since their last visit**? Provide dates as well.

_____

_____

Recent changes in family, living or school situation?

_____

_____

Is there concern about the patient **'s mental health or abilities in school?** _____**If the above answer is yes, please fill out a mental health questionnaire- ask a staff member or obtain from website link.**

Problems or concerns with any of the following, either in the child or a family member?

Heart

_____

Lungs

_____

Head/ears/nose/throat

Abdomen/Stomach/Intestines

Muscles or Joints

Nervous system

Depression or Anxiety

High blood pressure

High cholesterol

Diabetes

Thyroid disease

Cancer

Skin

Other

_____

Family History **Medical Problems**

Mother

Father

Brothers/Sisters

Grandparents

Other Health History

Does the patient smoke?

Is there a smoker in the household?

Does the patient drink alcohol? If so, how often?

Has the patient used illegal drugs or had issues with substance abuse?

Is the patient sexually active? _____ Using birth control?

Last dental appointment?

Last vision screen or eye doctor appointment?

Is there a family or household contact with **HIV, tuberculosis, Hepatitis C or any other infectious disease of concern?**

Are there any specific concerns you would like to address at this appointment?

List **current medications**, with dose and frequency, and any other vitamins and/or supplements taken by the patient

Do you have a copy of your **immunization record**? _____ If so , please provide us with a copy. If not, please obtain one from us or your prior provider.

Does the patient have a diet which is well-rounded and includes fruits, vegetables, protein, and a small amount of fats on a daily basis? _____ If not, what is missing?

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Patient History Form, 22-39

Name_____

Date of Birth_____ M or F

Occupation/Employer

_____

Other physicians or specialists seen within past 2 years

_____

_____

Allergies or reactions to medications?

_____

Have you been hospitalized for **illness** or **surgery since your last visit**? Provide dates as well.

_____

_____

_____

Last **dental** exam? _____ _____

Last **eye** exam? _____

Women - last **gynecologic** exam?

_____

Problems or concerns with any of the following?

Heart

_____

Lungs

_____

Head/ears/nose/throat

Abdomen/Stomach/Intestines

Muscles or Joints

Nervous system

Depression or Anxiety

High blood pressure

High cholesterol

Diabetes

Thyroid disease

Cancer

Skin

Other

Recent changes in family, living or employment situation?

_____

_____

_____

Family History **Medical Problems**

Mother

Father

Brothers/Sisters

Grandparents

Health Habits

Do you or did you ever smoke?

Drink alcohol?

Routine exercise?

Caffiene?

Have you ever had a problem with alcohol abuse or drug abuse (prescription or street drugs)?

Have you ever been physically or sexually abused?

Are there any specific concerns you would like to address at this appointment?

List **current medications**, with dose and frequency, and any **other vitamins and/or supplements**

Past Immunization History-give approximate date or supply immunization record

Tetanus/dT/Tdap?_____

Pneumonia vaccine?_____

Flu shot?_____

Hepatitis B?_____

Gardasil (HPV)?_____

Zostavax (Shingles)?_____

Other vaccines for school, travel, etc?

Do you have an advanced directive or living will? _____If so, please provide us with a copy.

If not, please talk to your provider about this. You can download the MOLST (Maryland Medical Order for Life-Sustaining Treatment) form and fill it out for this appointment.

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Bridge to Wellness

Patient History Form, 40-64

Name_____

Date of Birth_____ M or F

Occupation/Employer

_____

Other physicians or specialists seen within past 2 years

_____

_____

_____

Allergies or reactions to medications?

_____

Have you been hospitalized for **illness** or **surgery since your last visit**? Provide dates as well.

_____

_____

_____

Last **dental** exam? _____

Last **eye** exam? _____

Last **colonoscopy**? _____

Women - last **gynecologic** exam? _____

Last **mammogram**? _____

Men – last **PSA**? _____

Problems or concerns with any of the following?

Heart

_____

Lungs

_____

Head/ears/nose/throat

Abdomen/Stomach/Intestines

_____

Muscles or Joints

_____

Nervous system

_____

Depression or Anxiety

_____

High blood pressure

_____

High cholesterol

_____

Diabetes

_____

Thyroid disease

_____

Cancer

_____

Skin

_____

Other

_____

Recent changes in family, living or employment situation?

Family History **Medical Problems**

Mother

Father

Brothers/Sisters

Grandparents

Health Habits

Do you or did you ever smoke?

Drink alcohol?

Routine exercise?

Caffiene?

Have you ever had a problem with alcohol abuse or drug abuse (prescription or street drugs)?

Have you ever been physically or sexually abused?

Are there any specific concerns you would like to address at this appointment?

List **current medications**, with dose and frequency, and any **other vitamins and/or supplements**

Past Immunization History-give approximate date or supply immunization record

Tetanus/dT/Tdap?_____

Pneumonia vaccine?_____

Flu shot?_____

Hepatitis B?_____

Gardasil (HPV)?_____

Zostavax (Shingles)?_____

Other vaccines for school, travel, etc?

Do you have an advanced directive or living will? _____If so, please provide us with a copy.

If not, please talk to your provider about this. You can download the MOLST (Maryland Medical Order for Life-Sustaining Treatment) form and fill it out for this appointment.

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Bridge to Wellness

Patient History Form, 65-105

Name_____

Date of Birth_____ M or F

Employed, Volunteer, Retired or Disabled?

_____

Other physicians or specialists seen within past 2 years

_____

_____

_____

Allergies or reactions to medications?

_____

Have you been hospitalized for **illness** or **surgery since your last visit**? Provide dates as well.

_____

_____

Last **dental** exam? _____

Last **eye** exam? _____

Last **colonoscopy**? _____

Women - last **gynecologic** exam? _____

Last **mammogram**? _____

Men – last **PSA**? _____

Problems or concerns with any of the following?

Heart

_____

Lungs

_____

Head/ears/nose/throat

Abdomen/Stomach/Intestines

Muscles or Joints

Nervous system

Depression or Anxiety

High blood pressure

High cholesterol

Diabetes

Thyroid disease

Cancer

Skin

Other

Recent changes in family or living situation?

_____

_____

Family History **Medical Problems**

Mother

Father

Brothers/Sisters

Grandparents

Health Habits

Do you or did you ever smoke?

Drink alcohol?

Routine exercise?

Caffiene?

Have you ever had a problem with alcohol abuse or drug abuse (prescription or street drugs)?

Have you ever been physically or sexually abused?

Are there any specific concerns you would like to address at this appointment?

Do you have an advanced directive or living will? _____If so, please provide us with a copy.

If not, please talk to your provider about this. You can download the MOLST (Maryland Medical Order for Life-Sustaining Treatment) form and fill it out for this appointment.

List **current medications**, with dose and frequency, and any **other vitamins and/or supplements**

Past Immunization History-give approximate date or supply immunization record

Tetanus/dT/Tdap?_____

Pneumonia vaccine?_____

Flu shot?_____

Hepatitis B?_____

Gardasil (HPV)?_____

Zostavax (Shingles)?_____

Other vaccines for school, travel, etc?

If you are coming for a Medicare wellness check-up, please be sure to fill out the Medicare questionnaire