

BW PRIMARYCARE

Bridge to Wellness

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?

Caffeine?

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.