

BW PRIMARY CARE

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
