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 two (2) years: _____

_____

_____

Allergies or reactions to medications? ____
_____

Have you been hospitalized for illness or surgery since your last visit? Please provide dates below. _____

_____

_____

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 employment, family or living situation?
_____

_____

_____

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Family History of Past Medical Problems

Mother:
_____
Father:
_____
Brothers/Sisters:
_____

_____

_____
Grandparents:
_____

_____

_____

Health Habits
Do you or have you ever smoked?
_____
Drink alcohol?
_____
Routine exercise?
_____
Caffeine?
_____
Have you ever had a problem with alcohol abuse or drug abuse? (prescription or street)
_____
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 provide past immunization records.
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? Please provide a copy if yes. **Y / N**
If not, please ask your provider about this. Forms can be downloaded on our website.