

# INTEGRATIVE FAMILY WELLNESS CENTER

**Primary Care Physician:**

Name \_\_\_\_\_  
 Address \_\_\_\_\_

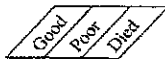
**PATIENT COMPLETES THIS SECTION**

Please use a ballpoint pen to answer all questions in this section. Put a \* next to any answer you would like to discuss with the doctor.

**A-PATIENT PROFILE**

Married  Divorced  Single  Separated  Widowed  
 Last school grade completed \_\_\_\_\_  
 Occupation \_\_\_\_\_ Since \_\_\_\_\_ Check if retired   
 Hobbies/Interests \_\_\_\_\_  
 Time since last complete medical examination \_\_\_\_\_

**B-HEALTH OF FAMILY**



If died, note age and cause (include fatal accidents and suicides)

Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brothers/Sisters:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**B1-GYN - Menarche** at \_\_\_\_\_ LMP \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Cycle \_\_\_\_\_  
 Flow \_\_\_\_\_ x days Abnormal Cramps Clots  
 Contraceptions \_\_\_\_\_ Hyst/Menopause at \_\_\_\_\_  
 Abnormal Bleeding/Spotting Discharge Dyspareunia  
 Last pap/pelvis: \_\_\_\_\_/\_\_\_\_/\_\_\_\_

**B2-OBSTETRICAL**

Pregnancy Total: \_\_\_\_\_ Mammogram \_\_\_\_\_  
 Term: \_\_\_\_\_ Date \_\_\_\_\_  
 Preterm: \_\_\_\_\_ Result \_\_\_\_\_  
 Miscar./Ab: \_\_\_\_\_

D.O.B.	Wt.	Name

**PHYSICIAN COMPLETES THIS SECTION**

Please use a ballpoint pen to underline positives in sections 1 through 12. Refer to section numbers in notes at the bottom and back of this page.

1. HEENT - Headache Vision change & last test \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_  
 Hearing change Sinus Congestion Swallowing  
 Dental problems & last exam: \_\_\_\_\_/\_\_\_\_/\_\_\_\_
2. NECK - Swollen glands Stiff Pain
3. RESPIRATORY - Cough
4. CARDIO/VASC. - Chest pain/discomfort Racing heart  
 High blood pressure Short of breath during sleep/exertion  
 Swollen feet Varicose veins
5. BREAST - Self exams Lump Pain Discharge
6. GI - Nausea Vomiting Pain Stool black/blood  
 Change in eating/bowel habits Bleeding

Today's Date: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

**C-ILLNESS** - If you have had any of the following, check the appropriate . If a blood relative has had any of the following, check the appropriate . F, M, MGF, MGM, PGF, PGM-Specify Blood Relative

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Alcoholism                                | <input type="checkbox"/> Epilepsy, seizures | <input type="checkbox"/> Cancer, tumor                |
| <input type="checkbox"/> Anemia                                    | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> High blood pressure          |
| <input type="checkbox"/> Bleed easily                              | <input type="checkbox"/> Heart disease      | <input type="checkbox"/> Ulcer in stomach or duodenum |
| <input type="checkbox"/> Diabetes                                  | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Nervous breakdown            |
| <input type="checkbox"/> Drug abuse                                | <input type="checkbox"/> Suicide attempt    | <input type="checkbox"/> Depression                   |
| <input type="checkbox"/> Eczema, hives, rashes                     | <input type="checkbox"/> Phlebitis          | <input type="checkbox"/> Eye problems                 |
| <input type="checkbox"/> Liver disease, hepatitis, yellow jaundice | <input type="checkbox"/> Thyroid disease    | <input type="checkbox"/> Mumps, measles, chicken pox  |
| <input type="checkbox"/> Lung disease                              | <input type="checkbox"/> Venereal disease   | <input type="checkbox"/> Rubella, German measles      |
|  |   | <input type="checkbox"/> Rheumatic fever              |

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_

**D-IMMUNIZATIONS** - Circle those that you have had and enter the year of the most recent if known.

Flu \_\_\_\_\_ Tetanus \_\_\_\_\_ Rubella \_\_\_\_\_  
 Pneumonia \_\_\_\_\_

**E-HOSPITALIZATIONS/SURGERY** - List illness or operations, and approximate year. EXCLUDE NORMAL PREGNANCIES.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**F-MEDICINES** - List all medicines, birth control pills, or vitamins you take with or without a prescription.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**G-MEDICINE ALLERGIES** - List all medicines that you are allergic to:

\_\_\_\_\_  
 \_\_\_\_\_

7. GU - Frequency Pain/burning Blood Stone Stress/incontinence  
 Start/stop difficulty Prostate trouble Sex difficulty
8. MUSCULO-SKELETAL - Bone or joint Pain/swelling/deformity
9. SKIN - Wart or mole changes Skin problems
10. NEUROLOGICAL - Seizures Trembling Dizziness Memory  
 Lose consciousness Behavior change
11. MOOD - Cry often Last time felt well: \_\_\_\_\_  
 Health worries Work/family problems Considered suicide
12. LIFE STYLE - Smoking Alcohol Drugs Sleep Exercise Meals  
 Sexual dissatisfaction Appetite Wt. change Job did/will change  
 Seat belts Marital problems/changes No. marriages \_\_\_\_\_  
 Family member: illness, disability, social/emotional problem

**Notes:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_