The Wellness and Prevention Center, LLC
19841 N. 27th Ave STE 204
Phoenix, AZ 85027
623-387-3705

Patient Name:_____
DOB: _____ Visit Date: _____
Chart #: _____

Patient Health History Form

Please answer the following questions to the best of your ability, if there is a section that is not applicable to you please write N/A. This will assist your provider in collecting information about you and your family. This document will be filed as part of your permanent record. **PLEASE USE BLACK OR BLUE INK, NOT PENCIL TO COMPLETE FORM.**

Age: _____ Sex: M F □ Married □ Single □ Widowed □ Divorced □ Separated, Religion:_____

Education highest completed: _____ Occupation: _____How long? _____Last physical exam: _____ Last blood work drawn: _____, Findings: _____, Date of last PAP:_____, Date of last Mammogram: _____, Date of last PSA: _____

List All Past Illness/Disease	Date	List All Operations	Date

Menstrual History: Age at first period _____ Date of last period: _____ Length of cycle: _____Number of days of flow: _____
I practice self breast exams? □ Y □ N Hormone Replacement Therapy? □ Y □ N Hx of abnormal pap? □ Y □ N, Number of pregnancies:_____ Number of miscarriages: _____, Sexual History: Is your partner □ Male □ Female □ Both, Hx of sexually transmitted diseases: □ HPV □ Gonorrhea □ Chlamydia □ Herpes □ N/A, Contraceptive Use? □ Y □ N Type: □ Tubal □ Vasectomy □ Pill □ Injection □ Barrier □ Rhythm □ Other _____ Hx: abnormal periods? □ Y □ N, Hx: Pain full Periods? □ Y □ N **Males:** I practice self testicular exams? □ Y □ N

Please CIRCLE illnesses or conditions you may have had or currently have

Diabetes	Heart Disease	Kidney Disease	Liver Disease	Asthma	Blood Transfusion	Emphysema	Intestinal Problems
Arthritis	Stomach Ulcers	Urinary Trouble	Bleeding Tendency	Bronchitis	Vein Trouble	HIV	Nervous Disorder
Cancer	Glaucoma	Osteoporosis	Rheumatic Fever	Seizures	Chemical Dependency	AIDS	Depression

Medication	Dose/Frequency	Medication	Dose/Frequency

Are you Allergic to Latex? □ Y □ N Are you allergic to any foods? _____
Please list all ALLERGIES to medications, seasonal, and substances: _____

Please complete side 2

FAMILY HISTORY (list chronic medical problems as well as cause of death)

	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	OTHER MEDICAL PROBLEMS
Father				
Mother				
Brothers				
Sisters				
Children				
Spouse or Partner				Spouse Name: _____

Please CIRCLE illnesses or conditions any blood relatives may have had

Diabetes	Heart Disease	Kidney Disease	Liver Disease	Asthma	Blood Transfusion	Emphysema	Intestinal Problems
Arthritis	Stomach Ulcers	Urinary Trouble	Bleeding Tendency	Bronchitis	Vein Trouble	HIV	Nervous Disorder
Cancer	Glaucoma	Osteoporosis	Rheumatic Fever	Seizures	Chemical Dependency	AIDS	Depression

PREVENTION: Date of last tetanus: _____ Date of last TB test: _____ Do you use tobacco now? □ Y □ N How much:_____ For how long? _____ Type: _____ Have you used tobacco in the past? □ Y □ N For how long? _____ How much: _____ Type: _____ When did you quite tobacco use? _____ Do you have the desire to stop tobacco use? □ Y □ N Do you drink Alcohol? □ Y □ N □ Not any longer but did in past, What type: _____ How frequently do you or did you drink Alcohol? _____ When did you stop drinking Alcohol? _____ Do you feel you have a drinking problem □ Y □ N Have you used recreational drugs? □ Y □ N What: _____ When: _____ Do you feel you have a drug problem? □ Y □ N Do you exercise □ Y □ N How often? _____ Do you wear a seatbelt □ Y □ N Do you feel safe in your home? □ Y □ N Do you feel safe in your current relationship □ Y □ N □ No relationship at this time, Do you have an advanced directive/living will? □ Y □ N Location: _____ If no are you interested in discussing this with your provider? □ Y □ N, I sleep _____hrs a night. I feel I get adequate sleep □ Y □ N.

What is the main reason for your visit today? _____

Please CIRCLE any active problems

General: Weakness Loss of energy Fatigue Weight loss Fever Chills Sleep disturbance , **Skin:** Rash Change in color itching, **Head:** Injury headaches, **Eyes:** Redness Change in vision Blurred vision Pain/Burning Tearing/Discharge I wear glasses □ Y □ N, **Ears:** Ringing Loss of hearing Dizziness Drainage I wear hearing a hearing aid □ Y □ N ear _____ **Nose:** Allergy Sinus trouble Drainage Bleeding Stuffy Post nasal drip, **Mouth/Throat:** Sores Bleeding gums Difficulty swallowing Sore throat Lump in throat Dentures upper lower, **Heart:** Chest pain Palpitations Fluttering Ankle swelling Shortness of breath I have a pace maker □ Y □ N I have stents □ Y □ N, **Breast:** Discharge Lumps Pain, **Lungs:** Cough Phlegm Blood Wheezing Bronchitis Hay fever Snoring, **Abdomen:** Pain Bleeding Jaundice Bowel changes Heart burn lack of control, **Genito-Urinary:** Burning Blood in urine Night urination Pain on urination Lack of control Sexual problems Painful intercourse Do you leak when you cough or sneeze? □ Y □ N Do you leak urine at any other time? □ Y □ N Would you like to discuss this with your provider? □ Y □ N, **Endocrine:** Thyroid disorders Diabetes, **Musculo-skeletal:** Back pain Arthritis Muscle pains Varicose veins Are you interested in being screened for osteoporosis? □ Y □ N, **Neurological:** Headache Seizures Stroke Weakness Imbalance Tingling Numbness, **Psychiatric:** Depression Anxiety Family problems Chemical dependency Consultation with Counselor/Psychiatrist, **Other:** _____

Additional Comments:

Patient/Guardian Signature Date: