WELLSTAR
Physicians Group

Patient Name: _____
Birth Date: _____

FAMILY HISTORY: Please give approximate date of onset of each disease, if known:

	Father	Mother	Bro ☐ Sis ☐	Bro ☐ Sis ☐	Bro ☐ Sis ☐	Bro ☐ Sis ☐
Year of Birth						
Year of Death						
Cause of Death						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Anemia						
Stroke						
Diabetes						
Cancer (type)						
Kidney Disease						
Asthma						
Tuberculosis						
Migraines						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Other:						
Other:						

FOR WOMEN ONLY:

Date of last menstrual period: _____

Difficulty with periods? ___Y ___N

Describe: _____

Changes in menstrual pattern? ___Y ___N

Describe: _____

When was your last Pap Smear? _____

Number of pregnancies: _____

Number of live births: _____

If menopausal, date of onset: _____

Date of last mammogram: _____

Do you practice breast self exam? _____Y ___N

What is your method of birth control? _____

FOR MEN ONLY:

Do you practice testicular self-exams? _____Y _____N Need Instruction: _____

Have you ever had a Prostate Screening Test? _____Y ____N Date: _____

What method of birth control do you use? _____

Patients Initials: _____ Provider Initials: _____

WELLSTAR
Physicians Group

PLEASE CHECK ANY RECENT OR RECURRING PROBLEMS YOU HAVE EXPERIENCED:

____Abdominal Pain	____Difficulty Swallowing	____Heartburn
____Back Pain	____Joint Pain	____Chest Pain
____Rapid Heart Rate	____Wheezing	____Cough
____Fever	____Swollen Glands	____Shortness of Breath
____Skin Rash	____Swelling of Extremities	____Difficulty Sleeping
____Depression	____Anxiety	____Reaction to Anesthesia
____Lack of Energy	____Constipation	____Nausea
____Hay Fever	____Nasal Congestion	____Headaches
____Problem Hearing	____Vision Problems	____Dizziness
____Fainting	____Abnormal Vaginal Bleeding	____ Rectal Bleeding
____Bleeding	____Pelvic Pain	____Hot Flashes
____Vaginal Discharge	____Poor Appetite	____Burning w/Urination
____Weight Gain	____Weight Loss	____Diarrhea
____Chills	____Unsafe work conditions	____Sexual Difficulties
____Violence at home	____Hazardous work or hobbies	

COMMUNICATION NEEDS:

Language if other than English: _____

Vision: _____ Normal _____ Glasses _____ Contacts _____ Blind

Hearing: _____ Normal _____ Hard of Hearing _____ Hearing Aid _____ Deaf

Interpreter Needed: _____ Y _____ N

Did someone else fill out this form? _____ Y _____ N Who? _____

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for you? ___Y ___N
If YES, explain: _____

ADVANCE DIRECTIVES:

Do you have an Advance Directive: ____Y ____N

If YES, do you have:

Living Will	____Y ____N
Durable Power of Attorney for Healthcare	____Y ____N
Directive for Final Healthcare	____Y ____N

Who would you want to make decisions for you in the event you are unable to make them for yourself? _____

_____

If you have an Advance Directive, please bring us a copy for your chart.

Patient Signature _____ Date _____

Provider Signature: _____ Date: _____