Wellstar Shallowford Medical Center - PLEASE PRINT _____
Date

_____ ___/___/_____ _____ Sex _____ (M) _____ (F)
Name (Please Print) Date of Birth Age

Marital Status ____(S) ____(M) ____(D) _____(W) Occupation _____Race _____

ALLERGIES: (MEDICATIONS) _____

ALLERGIES: (FOODS) _____
MEDICAL HISTORY – _____Colonoscopy _____ Tetanus _____Eye Exam _____Bone Density
Date Date Date Date
_____ Flu Shot _____ Zoster Vaccine (Shingles) _____Pneumonia Vaccine _____Mammogram _____PAP
Date Date Date Date Date
Current Medications _____

_____

Over the counter meds/herbal supplements _____

_____

Current Health Problems _____

_____

Previous Health Problems _____

Names of your other physicians/specialists:

_____

PATIENT RIGHTS – Is there anything we need to know about your religion or culture to care for you?

_____

Advance Directive – IF YOU HAVE AN ADVANCED DIRECTIVE, PLEASE BRING US A COPY FOR YOUR CHART.

Do you have an Advanced Directive ____ (yes) ____ (no**)**
Durable Power of Attorney _____ (yes) _____ (no) **Living Will** ___ (yes) ____(no)
Healthcare Proxy _____ (yes) _____ (no)

HOSPITALIZATIONS - SURGERIES	**Descriptions**	**Year**	**Reason**	**Hospital**
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

PERSONAL HABITS: If yes, how much and how often (please print)
Do you smoke? _____ (yes) _____ (no) _____
Have you ever smoked? _____ (yes) _____ (no) _____
Do you chew tobacco? _____ (yes) _____ (no) _____
Do you drink alcohol? _____ (yes) _____ (no) _____
Do you use drugs? _____ (yes) _____ (no) _____
Do you exercise regularly? _____ (yes) _____ (no) _____
Do use seat belts? _____ (yes) _____ (no) _____

(rev. 12-15-11)

Wellstar Shallowford Medical Center – PLEASE PRINT **SYSTEMS REVIEW**

_____ _____ _____/_____/_____
Patient Name **Date** **Date of Birth**

Please check NO or YES……

GENERAL

NO YES
(___) (___) Fatigue/feeling tired
(___) (___) Fever
(___) (___) Night sweats
(___) (___) Stress
(___) (___) Mood Changes
(___) (___) Sleep Problems

EAR, NOSE, THROAT, EYES

NO YES
(___) (___) Ear drainage
(___) (___) Hearing Loss
(___) (___) Nasal Drainage
(___) (___) Vision Loss
(___) (___) Eye Discharge

RESPIRATORY

NO YES
(___) (___) Cough
(___) (___) Shortness of Breath
(___) (___) Wheezing

CARDIOVASCULAR SYSTEM

NO YES
(___) (___) Chest pain or pressure
(___) (___) Rapid or irregular heartbeat
(___) (___) Poor Circulation

CIRCULATION

NO YES
(___) (___) Easy Bleeding
(___) (___) Easy Bruising

GASTROINTESTINAL SYSTEM

NO YES
(___) (___) Abdominal Pain
(___) (___) Constipation
(___) (___) Diarrhea
(___) (___) Vomiting

URINARY SYSTEM

NO YES
(___) (___) Painful Urination
(___) (___) Blood in urine

REPRODUCTVE SYSTEM – women

NO YES
(___) (___) Painful menstrual cycle
(___) (___) Heavy menstrual cycle
(___) (___) Abnormal vaginal discharge

REPORDUCTIVE SYSTEM – men only

NO YES
(___) (___) Penile Discharge

METABOLISM

(___) (___) Always feel cold
(___) (___) Always feel hot
(___) (___) Thirsty all the time
(___) (___) Hungry all the time

SKIN

NO YES
(___) (___) Itching
(___) (___) Rash

MUSCULOSKELETAL SYSTEM

NO YES
(___) (___) Bone/joint symptoms
(___) (___) Muscle weakness

NEUROLOGIC

NO YES
(___) (___) Headache
(___) (___) Dizziness
(___) (___) Numbness/Tingling

IMMUNE SYSTEM

NO YES
(___) (___) Outdoor Allergies
(___) (___) Food Allergies

ADDITIONAL INFORMATION: _____

_____

_____

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NAME _____ **DATE OF BIRTH** _____

FAMILY HISTORY:

	LIVING	DECEASED	List any significant health problems or cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	Date of Birth _____
	_____	_____	Date of Birth _____
	_____	_____	Date of Birth _____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____

IS THERE ANY FAMILY HISTORY OF:

NO	YES			NO	YES		
(___)	(___)	Heart Disease	Who? _____	(___)	(___)	Breast Cancer	Who? _____
(___)	(___)	Hypertension	Who? _____	(___)	(___)	Stroke	Who? _____
(___)	(___)	Mental Disorder	Who? _____	(___)	(___)	Alcoholism	Who? _____
(___)	(___)	Diabetes	Who? _____	(___)	(___)	Kidney Disease	Who? _____

WOMEN ONLY: Menstrual Periods – Age Onset _____Regular _____Yes _____No
Date of last period _____Difficult periods _____Yes _____No Specify _____
Age of Menopause _____ Lumps or discharge from breasts _____Yes _____No
Pregnancies (number) Live Birth _____ Premature _____Caesarian_____Miscarriage_____
Do you use birth control pills _____Do you practice self breast exams _____

MEN ONLY:

YES	NO	
(___)	(___)	Self exam testes

PHARMACY NAME _____**PHONE** _____

ADDRESS: _____

MAIL ORDER PHARMACY _____**ADDRESS** _____

_____