WellCentric HEALTH

Concierge Medicine

Health Questionnaire

This medical questionnaire will be helpful in developing a care plan for you. Please be as accurate as possible. I appreciate you taking the time filling it out.

Basic Information

Full Legal Name: ____

Nick Name(s): ____

Date of Birth: ____

Address: ____
____
____

Home Phone: ____
Cell Phone: ____
Email: ____
Your pharmacy/phone number: _______________________________________
Insurance Provider
Name/Policy #:____
Address:____
____

Previous Primary Care Provider and contact information

Name:____
Phone/Fax____

List your Specialists and Surgeons

____
____
____
____

Past Medical History

Please list all diagnoses, ***i.e Diabetes, high blood pressure, etc.***

____
____
____
____
____
____
____
____
____

Medications. ***Please list all medication prescribed and over the counter, herbs,_ etc..***

____
____
____
____
____
____
____
____
____

Allergies and Intolerances:

____
____
____
____

Past Surgical History. ***Please list any surgeries or procedures***

____
____
____
____
____

Social History

Tobacco use: Ever? If yes, how many years, how many cigarettes per day on average. ____
Did you quit? What is the date you quit? _____________________________

Alcohol use: How much, how often and type of alcohol?

____

____

Drug use: List any illicit drug use. Have you ever done IV drug use?

____

____

Occupation(s)/Retired?____

____

____

Highest Level of Education completed ______________________________

Hobbies/Interests:____

____

____

Religion____

Family History, *please list any medical conditions*

Were you adopted? _____________
Mother____

____

Father____

____

Siblings/Cousins____

____

____

____

Review of Systems

CHECKLIST: Review of Systems Checklist:

General- □ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness □ Trouble sleeping

____

Skin- □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes____

____

Head- □ Headache □ Head injury

____

____

Ears- □ Decreased hearing □ Ringing in ears (tinnitus) □ Earache □ Drainage

____

____

Eyes- □ Vision □ Glasses or contacts □ Pain □ Redness □ Blurry or double vision □ Flashing lights □ Specks □ Glaucoma □ Cataracts □ Last eye exam

____

____

Nose- □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus pain

____

____

Throat- □ Teeth □ Gums □ Bleeding □ Dentures □ Sore tongue □ Dry mouth □ Sore throat □ Hoarseness □ Thrush □ Non-healing sores □ Last dental exam____

____

Neck- □ Lumps □ Swollen glands □ Pain □ Stiffness

____

____

Breasts- □ Lumps □ Pain □ Discharge □ Self-exams □ Breast-feeding

____

____

Respiratory- □ Cough (dry or wet, productive) □ Sputum (color and amount) □ Coughing up blood (hemoptysis) □ Shortness of breath (dyspnea) □ Wheezing □ Painful breathing

____

____

Cardiovascular- □ Chest pain or discomfort □ Tightness □ Palpitations □ Shortness of breath with activity (dyspnea) □ Difficulty breathing lying down (orthopnea) □ Swelling (edema) □ Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

____

____

Gastrointestinal- □ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea □ Change in bowel habits □ Rectal bleeding □ Constipation □ Diarrhea □Yellow eyes or skin (jaundice)

____

____

Urinary- □ Frequency □ Urgency □ Burning or pain □ Blood in urine (hematuria) □ Incontinence □ Change in urinary strength

____

____

Genital

Male- □ Pain with sex □ Hernia □ Penile discharge □ Sores □ Masses or pain □ Erectile dysfunction □ STD's

Female- □ Pain with sex □ Vaginal dryness □ Hot flashes □ Vaginal discharge □ Itching or rash □ STD's

____

____

Vascular- □ Calf pain with walking (Claudication) □ Leg cramping

____

____

Musculoskeletal- □ Muscle or joint pain □ Stiffness □ Back pain □ Redness of joints □ Swelling of joints □ Trauma

____

____

Neurologic- □ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □ Tremor

____

____

Hematologic- □ Ease of bruising □ Ease of bleeding

____

____

Endocrine- □ Head or cold intolerance □ Sweating □ Frequent urination (polyuria) □ Thirst (polydypsia) □ Change in appetite (polyphagia)

____

____

Psychiatric- □ Nervousness □ Depression □ Memory loss □ Stress

____

____

Goals

What are your health and wellness goals?

____

____

____

____

____

____

____

Please contact me via text when you finish this form, so we can schedule your first appointment.

Thank you and see you soon!

Bob Dalrymple, MD
775-530-6626