Ramsey Wellness Clinic, PLLC
Convenient Care Made Simple

Patient Medical History Form

Name: _____ Age: _____ Date: _____
Vital Signs: BP _____ Pulse _____ Temperature _____
Height _____in. Weight_____lbs. Preliminary Goal Weight_____
BMI _____ Waist Circumference _____ Hip Circumference _____

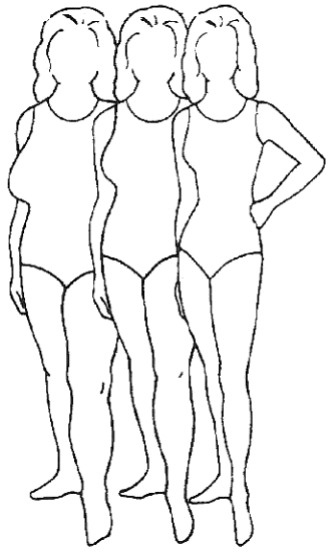
Diagnostics: Laboratory Results Reviewed

	Normal	Abnormal	
Urinalysis	☐	☐	_____
CBC	☐	☐	_____
Chemistry Profile	☐	☐	_____
Lipid Profile	☐	☐	_____
Thyroid Screen	☐	☐	_____
EKG Completed	☐	☐	_____

Body Composition Analysis _____% fat _____% lean

Initial Measurements

Neck _____	Shoulder_____
Arm _____	Ribs _____
Bust _____	Waist _____
Mid Section _____	Hips _____
Thighs _____	Calf _____
Ankle _____	



☐ Informed Consent Signed

Return in _____weeks for follow-up visit No. 1 _____

Ramsey
Wellness Clinic, PLLC
Convenient Care Made Simple

Patient Intake Form

Patient's Name_____ Age _____ Date _____

When did you first become overweight? (your age then) _____ (year) _____
How did your weight gain start? Describe any circumstances: _____
_____
What do you think is the cause of your weight problem? _____
_____
Your present weight: _____ your weight goal: _____ height: _____
What was your highest weight? (excluding pregnancy) _____your age then _____ # of years ago _____
What was your lowest weight? _____ your age then _____ # of years ago _____
Have you ever stayed the same weight for 10 years or more? Yes:/ No
Have you attempted to lose weight before? _____ most lbs lost: _____ how long it look: _____ Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture)
and describe your results:_____
_____
_____
_____
Where and when do you do most of your overeating?_____
_____
_____
Please make any comments that you think might be helpful: _____
_____
_____
_____
Do you currently have any medical concerns? Please List: _____
_____

Past History: (Please check if you have had any of the following):

☐ Birth defects or abnormalities	☐ Exposed to tuberculosis	☐ Measles	☐ Scarlatina
☐ Influenza	☐ Mumps	☐ Diphtheria	☐ Rheumatic
☐ Fever German Measles (3 day)	☐ Polio	☐ Whooping Cough	☐ Frequent Colds
☐ Chickenpox	☐ Tonsillitis	☐ Scarlet Fever	☐ Pneumonia
☐ Diabetes:Type: _____	☐ Cancer, Type: _____		
☐ Other Diseases _____	☐ Operations:(dates) _____		

Current Medications (vitamins, birth control pills): _____
_____
Allergies to medicines, foods, etc. _____

Family History:
Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____
# of siblings:_____ # living _____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure	☐ Allergy	☐ Heart trouble	☐ Anemia
☐ Migraine	☐ Bleeding (abnormal)	☐ Dropsy	☐ Epilepsy
☐ Strokes	☐ Cancer	☐ Diabetes	☐ Nervous breakdown
☐ Kidney disease	☐ Syphilis or (bad blood)	☐ Suicide	☐ Obesity
☐ Arthritis	☐ Rheumatic	☐ Fever	

☐ Other _____

Examinations:
Date of last physical examination _____ Reason _____
Hospitalizations _____ Dates _____ Reasons _____
X-Rays: Chest _____ Stomach _____ Gallbladder _____ Kidney _____Colon _____ Others _____ Electrocardiogram (heart tracing) _____
Laboratory tests: _____
Date of last pap (cancer smear) _____

Ramsey
Wellness Clinic, PLLC
Convenient Care Made Simple

Do you now have or have had any of the following?

☐ Itching	☐ Eczema	☐ Hives	☐ Joint pains	☐ Muscle aches
☐ Arthritis	☐ Limitation of motion	☐ Backache	☐ Leg pains	☐ Heel Pains
☐ Pain or stiffness (neck)		☐ Goiter	☐ Swelling, enlarged glands	☐ Asthma
☐ Lung disease		☐ Raise sputum	☐ Emphysema Bronchitis	☐ Heart trouble
☐ High blood pressure		☐ Shortness of breath	☐ Palpitation or fluttering	☐ Chest pain
☐ Lips or nails turn blue		☐ Tire easily	☐ Swelling of ankles	☐ Indigestion
☐ Nausea or vomiting		☐ Abdominal pain	☐ Gas or bloating	☐ Diarrhea
☐ Hard bowel movements		No. of bowel movements - daily _____		☐ Colitis
☐ Jaundice		☐ Hemorrhoids (piles)	☐ Bleeding or black stools	☐ Hernia
☐ Urinary System		☐ Kidney disease	☐ Bladder disease	☐ Kidney stones
☐ Painful urination		☐ Pus or blood in urine	☐ Albumen or sugar in urine	☐ Dribbling of urine
☐ Varicose veins		☐ Nervousness or anxiety	☐ Trouble sleeping	☐ Headaches
☐ Bored or depressed		☐ Nervous breakdown	☐ Fainting	☐ Convulsions
☐ Numbness		☐ Loss of consciousness	☐ Neuritis or Neuralgia	☐ Paralysis

Menstrual History:

Menstruation began at age _____ 28 day cycle? _____ If no, how many days? _____
Duration of bleeding _____ Pain with periods _____
Amount of flow _____ Light _____ Med. _____ Heavy _____
Date of 1st day of last: _____ menstrual period _____
Bleeding between periods _____ Bleeding after intercourse _____
Irritation or discharge _____ Itching or burning _____

I have read and understand all of the above and have agreed to these statements.

_____ _____
Patient's Signature Date

Ramsey
Wellness Clinic, PLLC
Convenient Care Made Simple

Patient Intake Form

Patient Name: (Last)_____(First)_____(MI)___
Name you prefer to be called: _____e-mail:_____
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____Beeper/Cellular: _____
Birthdate: _____Age: _____Sex: M F
Country of Birth: _____ Country of Parents' Birth: _____
Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School **(**Circle the highest level achieved)

Employment Information:
Patient Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Work phone No: _____Ext. _____
Social Security: _____Drivers License: _____

In Case of Emergency:
Name: _____Relationship: _____ Phone: _____
Patient's Spouse: _____ Phone: _____
Family Physician: _____ Phone: _____
Referred by: _____

Financial Policy:
Thank you for selecting Ramsey Wellness Clinic, PLLC for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

Photographs:
I do ____do not____ give permission for photographs and other audiovisual and graphic materials to be used by the *Ramsey Wellness Clinic. PLLC* for marketing, education - promotion purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos. This release may be revoked at any time by submitting a new release, or with a reasonable written request.

I have read and understand all of the above and have agreed to these statements.

_____ _____
Patient's Signature Date