Chads Wellness
p. 405-821-4398 f. 405-592-7412
chadswellness@gmail.com

Name____________________________________ Date____________________

Address____

Phone________________________ Email________________________________

Height_____________ Weight__________________ Date of Birth_____________

Drug Allergies____

Current Medications____

Past Medical History____

Past Surgical History____

Reason for visit____

Pharmacy name & Location____

I agree to the risks and benefits of prescribed and/or recommended OTC medications.

______________________________________ ____________________
Signature Date

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Name_________________________________ DOB___________ Date__________

Phone___________________. Gender___________

Circle the correct answer for each question. Explain all YES answers at the bottom.

Have you ever had:

Y N ALLERGIES
Y N ALCOHOLISM.
Y N. ANXIETY/DEPRESSION
Y N. ASTHMA
Y N BLOOD CLOTS
Y N BLOOD IN STOOL
Y N. CHEST PAIN
Y N. DIABETES
Y N. DIFFICULTY SWALLOWING
Y N LUNGS DISORDERS
Y N. BLURRED VISION
Y N. FAINTING/DIZZINESS
Y N GALL BLADDER TROUBLE
Y N. HEADACHES
Y N. HEAD INJURY
Y N. HEART ATTACK/HEART TROUBLE
Y N PROSTATE ISSUES
Y N FAMILY HISTORY OF THYROID CANCER
Y N PROSTATE ISSUES
Y N INJECTION SITE ISSUES

Y N. CONSTIPATION
Y N. HEPATITIS
Y N HOSPITALIZATIONS (LAST 5 YEARS)
Y N HIGH BLOOD PRESSURE
Y N. KIDNEY STONES/KIDNEY DISEASE
Y N. PANCREATITIS
Y N CANCER
Y N PNEUMINIA
Y N. SEVERE STOMACH PAIN
Y N. SHORTNESS OF BREATH
Y N. STOMACH ULCERS
Y N. SURGERY
Y N. URINARY TRACT INFECTIONS
Y N THOUGHTS OF SUICIDE
Y N ATTEMPTED SUICIDE
Y N GASTROPORESIS
Y N. THYROID ISSUES
Y N. MEN 2 SYNDROME
Y N BLOOD CELL ISSUES
Y N GERD/REFLUX

Explain any YES answers____