

**Connect Health + Wellness**

Bassett: 324 T B Stanley Hwy. | Bassett, VA 24055

Ridgeway: 4944 Greensboro Rd. | Ridgeway, VA 24148

Dental: 23 Fayette St. | Martinsville, VA 24112

Patrick Springs: 22121 Jeb Stuart Hwy. | Stuart, VA 24171

Patient's Name: _____ Date of Birth: _____

Past Medical History

Previous Physician's name: _____ Date of Last Exam: _____

Which of the following conditions are you currently being treated or have been treated for in the past?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Eye disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease/Murmur/Angina |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney/Bladder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver problems/Hepatitis |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Thyroid problems |

Preventive Testing:

- 1) Date of last Pap smear: _____ Have you had an abnormal pap? _____
Where was your last pap performed? _____
- 2) Date of last mammogram: _____
Where was your last mammogram performed? _____
- 3) Date of last colonoscopy: _____
Where was your last colonoscopy performed? _____
- 4) Date of last PSA testing? _____
Where was your last PSA testing performed? _____
- 5) Where did you have your last immunizations? _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate. I also give Connect Health + Wellness permission to obtain results for the above via the Release/Exchange of Medical Records Form.

Patient / Legal Guardian Signature _____ Date _____