



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** _____