HOPE
WELLNESS CENTER
Formerly Hope Medical • Dental Clinic, Inc.

1125 Forrest Avenue, Suite 202, Dover, DE 19904
PH: (302)735-7551 F: (302)735-4746

New Patient Registration (Please Print Clearly)

Patient Name: _____ Date of Birth: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Social Security Number: _____

Race: _____ Gender: _____ Email: _____

Do you consent to receive communication about care via email? ☐ Yes ☐ No

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other_____

Are you a veteran? ☐ Yes ☐ No Occupation and Employer: _____

Emergency Contact

Name: _____ Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Relationship: _____

Do we have permission to speak with this person regarding your medical information? ☐ Yes ☐ No

Recent Surgeries/ Hospitalizations (date and reason):

_____

_____

Allergies: _____

Preferred Pharmacy (select one):

☐ Atlantic Apothecary
103 S. DuPont Blvd. #2
Smyrna, DE 19977
(302) 653-9355

☐ Forest Pharmacy
1030 Forrest Ave. # 111
Dover, DE 19904
(302) 994-3131

☐ Camden Pharmacy
4598 S. DuPont Hwy.
Camden, DE 19934
(302) 535-8604

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Medications

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Some questions on this form are specific to certain organs or screenings. Please answer the ones that apply to your body and medical history.

Please indicate the date of your last…

Colonoscopy: _____ Mammogram: _____

Menstrual Cycle: _____ Pap Smear: _____

Prostate Exam: _____ Wellness Exam: _____

Substance Use

We ask this only to better understand your overall health and provide the best care possible. Many people use substances in different ways and your response simply helps us ensure your safety with medications and treatment. We know these questions can feel personal. Please know your answers are private, judgment-free, and used only to support your wellness.

Alcohol	☐ Currently Use	☐ Used in Past	☐ Never Used	☐ Prefer Not to Answer
Marijuana/THC	☐ Currently Use	☐ Used in Past	☐ Never Used	☐ Prefer Not to Answer
Tobacco	☐ Currently Use	☐ Used in Past	☐ Never Used	☐ Prefer Not to Answer
Other Substance(s)	☐ Currently Use	☐ Used in Past	☐ Never Used	☐ Prefer Not to Answer

Have you ever been hospitalized or received treatment for alcohol or substance abuse?

☐ Yes ☐ No ☐ Prefer Not to Answer

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Personal and Family Medical History (Check all that apply)

Self	Family	Heart and Circulation
☐	☐	Blood Clots/Circulation Problems
☐	☐	High Blood Pressure/Hypertension
☐	☐	High Cholesterol
☐	☐	Heart Disease/Heart Attack
☐	☐	Irregular Heartbeat/Arrhythmia
☐	☐	Pulmonary Issue
☐	☐	Sickle Cell Disease
☐	☐	Stroke or Mini-Stroke (TIA)

Self	Family	Lungs and Breathing
☐	☐	Asthma
☐	☐	Chronic Bronchitis
☐	☐	COPD
☐	☐	Emphysema
☐	☐	Sleep Apnea
☐	☐	Other Lung Condition: _____

Self	Family	Metabolic and Endocrine
☐	☐	Diabetes Type 1
☐	☐	Diabetes Type 2
☐	☐	Thyroid Disorder

Self	Family	Stomach, Liver, and Kidneys
☐	☐	Acid Reflux/GERD
☐	☐	Kidney Disease/Kidney Stones
☐	☐	Liver Disease/Hepatitis
☐	☐	Ulcers or Stomach Problems

Self	Family	Brain, Nerves, and Mental Health
☐	☐	ADHD
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Headaches/Migraines
☐	☐	Memory Problems or Dementia
☐	☐	Seizures/Epilepsy
☐	☐	Other: _____

Self	Family	Muscles, Bones, and Joints
☐	☐	Arthritis
☐	☐	Back or Neck Problems
☐	☐	Chronic Pain/Fibromyalgia
☐	☐	Musculoskeletal Disorders
☐	☐	Osteoporosis

Self	Family	Immune System and Blood
☐	☐	AIDS/HIV
☐	☐	Anemia/Blood Disorder
☐	☐	Autoimmune Disease
☐	☐	Cancer (type: _____)

Self	Family	Reproductive and Urinary
☐	☐	Endometriosis/PCOS/Fibroids
☐	☐	Kidney/Bladder Problems
☐	☐	Menstrual or Hormone Disorder
☐	☐	Prostate Condition
☐	☐	Sexually Transmitted Infection
		☐ Current ☐ Past

Other (specify): _____

Patient Signature: _____ **Date:** _____