Capitol Wellness Center

Date: _____

Patient Name: _____

First Name Middle Initial Last Name

DOB (required): _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Place of birth:_____ Preferred Language:_____

Are you active Military or a US Veteran? □ Yes □ No

Employment Status (Check one):

□ Full Time □ Part Time □ Not Employed. □ Student (PT) □Student(FT) □ Retired □ Self-Employed

Occupation: _____ Employer: _____ Hrs/wk: _____

What is your preferred pharmacy (name and address)? _____

Are you currently receiving care from another provider? □ Yes □ No

If 'Yes': Name of the provider: _____ Clinic/hospital name: _____

Treatment you are currently receiving: _____

If 'No': When and where was the last time you've received medical care?_____

When did you last have your blood drawn for lab work: _____

(Please provide copies of this lab work before your first appointment)

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Family History

Please put an "L" for living and "D" for deceased and present age or age at time of death. Indicate if the family member suffered from any disease or conditions such as cancer, high blood pressure, heart attack, stroke or diabetes.

Relationship	L/D	Age	Health Conditions/Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings (specify brothers/sisters)			

Additional information regarding family history: _____

Social History

Tobacco Use: ☐ Current Smoker- Since (year): _____ ☐ Former Smoker- Quit (year)_____ ☒ Never

Alcohol Use: ☒ Yes- how many drinks a week? ____ ☒ No ☒ Occasionally

Any history of substance abuse? ☒ Yes ☒ No

If 'Yes,' please specify substance(s): _____

Treatment for dependence? When and where? _____

General Health

MEDICATIONS:

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking - *please include start date and dosage:

(1) _____ (4)_____

(2)_____ (5) _____

(3)_____ (6)_____

Have you taken antibiotics within the last year? Y / N If so, why?_____

*Have you had past tick exposure? Y / N If 'Yes,' when and where?_____

SURGERIES:

1) Procedure:_____ Hospital:_____ Date:_____

2) Procedure:_____ Hospital:_____ Date:_____

3) Procedure:_____ Hospital:_____ Date:_____

PREGNANCY:

How many children do you have? _____ Vaginal or C-Section birth? _____

Please list any pregnancy complications including miscarriage:

_____

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ALLERGIES/INSENSITIVITIES (food, plants, chemicals, etc.) - *Please include reaction(s):

(1) _____ (3)_____

(2)_____ (4) _____

LIFESTYLE:

Food Intake:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drinks:_____

How often do you exercise?_____ Physical activities: _____

REVIEW OF SYSTEMS QUESTIONNAIRE

(Check all that apply)

Constitutional: × Recent weight change? × Weakness, fatigue or chills? × Other- specify:_____

Psych: × Depression? × Anxiety? × Other psychiatric problems? Specify:_____

Sleep: × Difficulty falling asleep? × Interrupted sleep? × Sleep walking? × Talking in sleep?
Number of hours per night? _____ × Other- specify:_____

Eyes: × Difficulty seeing? × Contact Lenses? ×Temporary loss of vision? × Other- specify:_____

Ears, Nose, Throat: × Dentures × Problems with hearing? × Hoarseness, sore throat, trouble swallowing?
× Other- specify:_____

Cardiovascular: × Chest pain (heart pain, angina)? × Known heart rhythm problems? × Leaky heart valves?
× Problems with circulation? × High or low blood pressure? × Other- specify:_____

Respiratory: × Chronic cough? ×Shortness of breath with exertion? ×Wheezing/asthma symptoms?
× Other- specify:_____

GI: × Constipation or Diarrhea (please circle) × History of jaundice? × Recent change in appetite?
× Blood or mucus in stool? × Frequent heartburn or indigestion? × Stomach pain? × Other- specify:_____

GU: × Frequent bladder infections? × Frequent nighttime urination? × Incontinence? × Other- specify:_____

Skin: × Rashes? × Skin Cancers? × Other major skin problems? × Other- specify:_____

Neuro: × TIA's or minor stroke? × Recent numbness or weakness? × History of seizures? × Other- specify:_____

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Endocrine: × History of high or low blood sugar? × Thyroid problems (hypo/hyper)? × Other- specify:_____

Heme/Lymph: × Bleeding tendencies/bruising, or frequent nose bleeds? × Any history of anemia?
× Do you have sickle cell disease? × Other- specify:_____

Breasts: × Pain? × Discharge? × Other changes or abnormalities? Specify:_____

Musculoskeletal: × Joint pain requiring medicine? × Calf or leg pain with walking? × Arthritis?
× Pain? × Stiffness? × Swelling? × Numbness? × Tightness? × Burning/heat?
× Coldness? × Twitching? × Tremors? × Weakness? × Paralysis? × Shooting pains?
× Other- specify:_____

How do you alleviate the pain(s)?_____

Please write below any other concerns or priorities for your healthcare that should be addressed during your appointment:

*The information you provide will help to serve and assist reaching your health goals. Your answers are both voluntary and private

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