MCKINSEY HEALTH & WELLNESS

Medical and Aesthetic Concierge Services

Medical Registration and Information

Name (Last/First):_____

Today's Date:_____

Date of Birth: _____

Address:

_____

City:_____State:_____Zip: _____

Phone:_____Home () Cell () Work ()

Email Address:

_____

Married: () Single: ()

Emergency Contact Name:

_____

Emergency Contact Phone:

_____

Relationship to you:

_____

Pharmacy Name & Phone:

_____

What is the reason for your visit?

_____

How did you hear about us?

_____

Health History

SYMPTOMS Check symptoms you currently have

GENERAL
□ Major weight gain
□ Major weight loss
□ Fatigue
□ Changes in sleep pattern
□ Fever

EYE, EAR, NOSE, THROAT
□ Sore Throat
□ Mouth Sores
□ Visual changes
□ Double vision
□ Ringing in the ears
□ Hearing loss
□ Ear pain
□ Sinus congestion or pain
□ Nosebleeds
□ Hoarseness
□ Difficulty swallowing

DERMATOLOGICAL
□ Rash
□ Warts
□ Itching

BREASTS
□ Pain
□ Lumps
□ Discharge

RESPIRATORY
□ Wheezing
□ Coughing
□ Shortness of breath
□ Coughing up blood

CARDIOVASCULAR
□ Chest pain
□ Palpitations
□ Murmur
□ Rapid Heartbeat
□ Swollen Feet
□ Swollen Hands

GASTROINTESTINAL
□ Pain
□ Nausea
□ Vomiting
□ Diarrhea
□ Changes in appetite
□ Constipation
□ Rectal bleeding

MUSCLE/JOINT/BONE
□ Muscle pain
□ Joint pain
□ Decreased range of motion
□ Weakness

NEUROLOGICAL
□ Frequent headaches
□ Dizziness
□ Loss of conciseness
□ Seizures
□ Numbness/Tingling

ENDOCRINE
□ Intolerance to heat
□ Intolerance to cold
□ Excessive hunger
□ Excessive thirst

PSYCHIATRIC
□ Anxiety
□ Depression
□ Insomnia
□ Irritable
□ Suicidal thoughts

GENITOURINARY
□ Burning Urination
□ Frequent Urination
□ Blood in Urine

QUESTIONS

Are you pregnant?
_____ Yes_____No

Last Menstrual Period

Are you planning to become pregnant?
_____ Yes_____No

Do you Smoke?_____
_____ Per Day
_____ Per Week
_____ Per Month

Do you drink Alcohol?_____
_____ Per Day
_____ Per Week
_____ Per Month

Primary care physician

Personal History

Check conditions you have or have had in the past

□ AIDS □ Alcoholism □ Anemia □ Anorexia □ Appendicitis □ Arthritis □ Asthma □ Bleeding Disorders □ Breast Lump □ Bronchitis □ Bulimia	□ Cancer □ Cataracts □ Chemical dependency □ Diabetes □ Emphysema □ Epilepsy □ Glaucoma □ Goiter □ Heart Disease □ Hepatitis □ High Cholesterol	□ HIV Positive □ Kidney Disease □ Liver Disease □ Migraine Headaches □ Miscarriage □ Mononucleosis □ Multiple Sclerosis □ Pacemaker □ Pneumonia □ Psychiatric Care □ Stroke	□ Suicide Attempt □ Thyroid Problems □ Tuberculosis □ Ulcers □ Sexually transmitted Disease Type_____ □ Other (please list) _____

Surgery History

Surgery	Year	Reason	Hospital

Family History

Check conditions that your immediate family (Grandparents, Parents, or Siblings) may have or have had

□ Diabetes _____ □ Heart Disease _____ □ Cancer*	□ Mental Illness _____ □ Stroke _____ □Type of Cancer*	□ Bleeding tendency _____ □ Kidney Disease _____ □ Type of Cancer Cont'	□ High blood Pressure _____ □ Other _____ □ Other
□ Cancer*	□Type of Cancer*	□ Type of Cancer Cont'	

MEDICATIONS: List all medications you take (***Including over the counter medications & herbs and medications taken as needed)***)

Medication	Strength	How often	Reason	Prescribing Physician

ALLERGIES: List all allergies (**medications or substances**)

Allergy	Reaction