Wilmington Health and Wellness

265 Racine Dr. Ste. 100
Wilmington, NC 28403
PHONE: 910-798-5560

DATE:_____

PATIENT DEMOGRAPHICS

FULL NAME:_____ DATE OF BIRTH:_____

GENDER: ☐ FEMALE☐ MALE DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)?☐ YES ☐ NO

HOME ADDRESS:_____

CITY:_____STATE:_____ ZIP CODE:_____

EMAIL:_____

PRIMARY PHONE:_____☐HOME☐MOBILE☐WORK☐SPOUSE☐CAREGIVER☐OTHER

SECONDARY PHONE: _____☐HOME☐MOBILE☐WORK☐SPOUSE☐CAREGIVER☐OTHER

INSURANCE NAME: _____SUBSCRIBER ID:_____GROUP:_____

SOCIAL SECURITY #:_____ REFERRED BY:_____

NEXT OF KIN (FOR EMERGENCY): _____

RELATION: _____PHONE: _____

CURRENT HEALTH PROBLEMS (LIST IN ORDER OF SEVERITY)

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

CURRENT PROVIDERS

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER			
NAME	STRENGTH	DIRECTION	PRESCRIBED BY

SURGERIES

1. _____ YEAR: _____ 4. _____ YEAR: _____

2. _____ YEAR: _____ 5. _____ YEAR: _____

3. _____ YEAR: _____ 6. _____ YEAR: _____

CHILDHOOD ILLNESSES

1. _____ 3. _____

2. _____ 4. _____

FAMILY HISTORY

	LIVING/DECEASED	AGE	MEDICAL PROBLEMS
FATHER:			
MOTHER:			
BROTHER(S):			
SISTER(S):			
MOTHER'S FATHER:			
MOTHER'S MOTHER:			
FATHER'S FATHER:			
FATHER'S MOTHER:			

FOLLOWING

GLAUCOMA/EYE EXAM: _____ HEPATITIS B SHOT:_____ FLU VACCINE:_____

PNEUMONIA VACCINE:_____ ZOSTAVAX SHOT:_____ BONE DENSITY SCAN:_____

COLONOSCOPY:_____ GLUCOSE: _____ ECHOCARDIOGRAM: _____

HEARING EXAM: _____ HEMOCULT: _____ LIPID PANEL: _____

MAMMOGRAM: _____ PAP SMEAR: _____ PELVIC EXAM: _____

PROSTATE EXAM: _____ PSA TEST: _____ RECTAL EXAM: _____

ABDOMINAL AORTIC ANEURYSM SCREENING:_____ TETANUS DIPHTHERIA VACCINE:_____

DIABETES SELF MANAGEMENT TRAINING: _____ NUTRITIONAL THERAPY: _____

SMOKING CESSATION: _____

SOCIAL

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH? _____

ARE OTHERS CONCERNED ABOUT YOUR DRINKING? ☐ YES ☐ NO

DIET: ☐ BALANCED ☐ VEGETARIAN ☐ DIABETIC ☐ LOW SALT ☐ LOW FAT ☐ LOW CARB ☐ OTHER:_____

EDUCATION: ☐ HIGH SCHOOL☐ COLLEGE ☐ SOME COLLEGE ☐ TRADE SCHOOL ☐ OTHER: _____

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? ☐ YES ☐ NO IF YES, HOW MUCH? _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER: _____

OCCUPATION: _____HOW LONG AT CURRENT EMPLOYER: _____

LIST EVERYONE IN YOUR HOUSEHOLD (INCLUDING PETS):

_____ _____ _____

_____ _____ _____

_____ _____ _____

HAVE YOU EVER SMOKED OR CHEWED TOBACCO? ☐ YES ☐ NO IF YES, HOW MUCH? _____

DO YOU FEEL LITTLE INTEREST/PLEASURE IN DOING THINGS? ☐ YES ☐ NO ☐ SOMETIMES

DO YOU FEEL DOWN, DEPRESSED, OR HOPELESS? ☐ YES ☐ NO ☐ SOMETIMES

ARE YOU AFRAID OF FALLING? ☐ YES ☐ NO ☐ SOMETIMES

HAVE YOU FALLEN IN THE PAST YEAR? ☐ YES ☐ NO

AUTHORIZED SIGNATURE:_____DATE:_____