Universal Wellness Group
Serving with Compassion
1220 59th St West; Bradenton, FL 34209

INITIAL PATIENT INTAKE AND HISTORY FORM

Name: _
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: Sex: ☐ Male ☐ Female **SS#:** _

Email address: _____

Phone # (Main) _____ (Other) _

Can we call you at work? ❑ Yes ❑ No Can we leave medical information on your phone? Yes ☐ ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _ Employer:

Employer Address: _ _____

City: _____ State: _____ Zip: _____

Employer Phone: _____

How did you hear about our practice? _

Emergency contact: Name: _____ Relation: _

Phone #: (H)_ (W) _

Preferred Pharmacy: Name: _____ Phone #: _____

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Local Pharmacy Address: _____
(Address/City)

Do you use a mail order pharmacy? _____ If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Preferred Mail Order Pharmacy: _____

*****Should your information change, please report these changes in your address, phone contact numbers, insurance, or emergency contact, information to the front desk upon check in at future visits*****

Reason(s) for coming to the doctor today:

_____

_____

_____

- Has a previous Provider provided treatment for the reason you are being seen today?

If yes, please provide Provider information. _____

- Do you currently **follow up with any other Provider/Specialist?** (Example: Cardiology, Neurology, Urology, Endocrinology, Infection disease, Mental Health, Nephrology, Therapy, Optometry, Orthopedics, ENT.)

If so please list the provider(s) you are following up with:

_____

_____

Healthcare Maintenance Screening (please list the most recent date if applicable)

	Date completed	**Who and Where performed or administered?**
Date of Colonoscopy:		
Date of Last Cologuard Test:		
Date of Mammogram:		
Date of Last Pneumonia shot: Prevnar or Pneumovax 23		
Date of Last Flu shot:		
Date of Last Eye Exam:		
Date of Last Bone Denisty Study (DEXA):		
Date of Last Pap Smear:		
Date of Last Tetanus Shot:		
Date of Last Zostavax (Shingles Vaccine):		

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Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

☐ Abdominal Pain	☐ GERD	☐ Prostate Disease
☐ Abnormal Vaginal Bleeding	☐ Gout	☐ Rash
☐ Anemia	☐ Headaches, Chronic	☐ Rheumatic Fever
☐ Anxiety	☐ Heart Disease	☐ Rubella
☐ Arthritis	☐ Heart Murmur	☐ Scarlet Fever
☐ Asthma	☐ Heart Palpations	☐ Seasonal Allergies
☐ Back Pain	☐ Hemorrhoids	☐ Seizure
☐ Cancer	☐ Hepatitis	☐ Sinusitis
☐ Colitis, Ulcerative	☐ High Blood Pressure	☐ Sleep Disorder
☐ COPD	☐ Incontinence	☐ Somnolence
☐ Crohn's	☐ Irritable Bowel	☐ Stroke
☐ Deep Vein Thrombophlebitis	☐ Kidney Stone(s)	☐ Tendinitis
☐ Dementia	☐ Measles	☐ Thyroid Disorder
☐ Depression	☐ Migraines	☐ Tuberculosis
☐ Diabetes	☐ MRSA Infection	☐ Ulcer
☐ Diverticulitis	☐ Mumps	☐ Urinary Frequency
☐ Dizziness	☐ Osteoporosis	☐ Urinary Pain
☐ ED (erectile dysfunction)	☐ Polio	☐ Vascular Disease, Peripheral
☐ GI Bleed	☐ Guillain Barre Syndrome	

List any other important **medical condition**(s) and **or Surgeries** you have had (do not include common colds or flu). Include date or age of initial diagnosis/surgery if possible: (continue on back if necessary)

Problem/Previous Diagnosis *Date(s) or Age*

_____

_____

_____

_____

_____

_____

Allergy History:

List known allergies (including medication allergies) and reaction to allergen. Or check one of the boxes below:

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA)

_____

_____

_____

_____

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Medication History:

List any medications and vitamins/minerals/herbs that you are currently taking.
Ensure to **include Name, Dose, and Frequency of medication(s).** or Bring Medication Bottles or Completed List with you to appointment.

☐No Current Meds

_____
_____
_____
_____
_____
_____

Social History:

Do you use tobacco products? ☐Never used ☐Former use ☐Current use ☐Unknown
How often? ☐Rare ☐Social ☐Daily
What type? ☐Cigarettes ☐Chewing Tobacco ☐Cigars

Are you exposed to "second-hand" smoke**?** ☐Yes ☐No
If yes, please indicate by marking the appropriate boxes: ☐Minimal ☐Frequent ☐Daily
☐Family members smoke indoors ☐Family members smoke outdoors only

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Vigorous

Do you drink beverages with caffeine? ☐Yes ☐No
What type? ☐Coffee ☐Tea ☐Carbonated Beverages

Have you ever used any illicit drugs? ☐Yes ☐No
How often? ☐Quit ☐Social Use ☐Regular Use ☐Daily Use
What type? ☐Uses marijuana ☐Uses cocaine ☐Uses methamphetamines

Do you drink beverages with alcohol? ☐Yes ☐No
How often? ☐Occasional use ☐Moderate use ☐Heavy use
What type? ☐Beer ☐Hard Liquor ☐Wine

What is your most recent primary occupation? _____

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Family History:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)?

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Sister	Brother	Son	Daughter
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible:

Family member *medical condition*

_____

_____

Diagnostic Studies: (mark only those that apply)

Dignostic Study	Date Performed	Who and Where Study performed
Angiography (Heart Catheterization:		
Cardiac Stress Test:		
Cardiac Echocardiogram:		
EKG:		
EGD:(esophagogastroduodenoscopy)		
EEG: (electroencephalogram)		
Pulmonary Function Test (PFT):		
Sleep Study:		
Spirometry:		