LWR WELLNESS, PLLC
805 Alexa Drive
Mt. Sterling, KY 40353
859-498-5105

Patient's Full Name: _____

Patient's Birth date: _____ **Social Security Number:** _____

Sex: ☐ **Male** ☐ **Female**
Marital Status: ☐ **Married** ☐ **Single** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Street Address: _____

Home Phone #: _____ **Work #:** _____ **Cell #:** _____

Spouse's Name: _____

If child, Parent / Guardian Name: _____ **Birth date:** _____

Currently: ☐ **Employed** ☐ **Unemployed** ☐ **Disability** ☐ **Retired**

Employer / Company Name: _____ **Phone #:** _____

Family Doctor's Name: _____ **Referred by:** _____

Pharmacy Name and Address: _____ **City:** _____

PLEASE HAVE PHOTO ID READY AT EACH OFFICE VISIT
(You must have ID with you at the time of service and pay for the full amount charged.)

MEDICATION HISTORY CONSENT: I give permission for **L. William Roberts, M.D.** to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Signed: _____ Date: _____

PLEASE COMPLETE AND RETURN TO FRONT DESK
WE ONLY ACCEPT CASH, CASHIER CHECK OR MONEY ORDER

Patient's Name:_____ **Date:**_____

MEDICATIONS/ALLERGY HISTORY

Note: If you have a list, please give to clinical staff.

List all prescription medicine, including inhalers, nasal sprays, topical medicine…
List all vitamins, minerals, herbal / health supplements (e.g., Valerian)…
List any other non-prescription meds you take (e.g. Benadryl, Melatonin, Tylenol)…

NAME	DOSAGE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

List all medications you are allergic to or react badly to (and describe the reaction).

MEDICATION	REACTION
1.	
2.	
3.	
4.	

List all allergies to animals, plants, dust, food, etc… ***(Describe reactions)***

_____

_____

Did you ever have an x-ray test where dye (contrast) was injected into your vein? ☐ **Yes** ☐ **No**
If yes, describe any allergic reaction or side effects from the dye.

_____

_____

Have you ever had allergy testing (skin testing)? ☐ **Yes** ☐ **No**
Have you ever received allergy shots? ☐ **Yes** ☐ **No** **When:** _____

When and where did you get your last…

Flu Shot (influenza vaccine)? _____ Pneumonia vaccine? _____

PPD (TB skin test)? _____ Chest X-Ray? _____

Patient's Name:_____ **Date:**_____

MEDICAL HISTORY

Please check [X] all medical conditions you have or have had in the past.

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Clots in the lung
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Diabetes
- ☐ Esophageal Dysmotility
- ☐ Emphysema
- ☐ HIV
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Heartburn / Reflux
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Liver Disease
- ☐ Shortness of Breath
- ☐ Thyroid Disease
- ☐ Currently Pregnant
- ☐ Back Injury

SOCIAL HISTORY

Check the appropriate boxes that apply:

☐ Current Smoker

_____ Total Years Smoking

_____ How old were you when you started?

☐ Former Smoker ☐ Never Smoked

☐ Alcohol / Caffeinated Beverages use

YES NO Alcohol If yes, how much per day? _____ Per week? _____

YES NO Caffeinated Drinks If yes, how much per day? _____ Per week? _____

☐ What hazardous materials, fumes, dusts, chemicals, and etc have you been exposed to at work or associated within your hobbies? _____

(e.g. *exotic birds, bird feathers, grain dust, moldy hay, solder, asbestos, paint fumes, Beryllium, welding, sand blasting, heavy metals, pesticides, baking flour dust)*

Patient's Name:_____ **Date:**_____

SURGRICAL HISTORY

List all surgeries you have had (lifelong):		List all non-surgical hospitalizations:	
Type of Surgery	Date of Surgery	Type of Non-Surgical Hospitalizations	Date of Surgery
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	

Name:_____ **Date:**_____

	No	Yes/Past or Yes/Now	How ? IV, Snort, Smoke, ect.	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD/ Hallucinogens							
Marijuana							
Methadone							
Vicodin							
Percocet							
Oxycodone							
Oxycotin							
Oxymorphone							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping							
Ecstasy							
Street Suboxone							
Other							