

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)?
Have you ever received allergy shots?

Yes No
 Yes No When: _____

When and where did you get your last...

Flu Shot (influenza vaccine)? _____
PPD (TB skin test)? _____

Pneumonia vaccine? _____
Chest X-Ray? _____

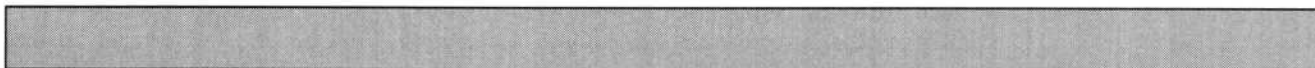
Patient's Name: _____ Date: _____



MEDICAL HISTORY

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

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

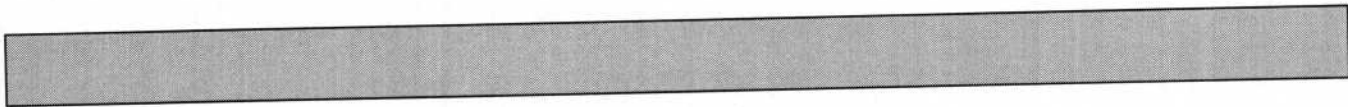


SOCIAL HISTORY

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							