Chart #______________
Date: ________________

NEW PATIENT INFORMATION

GENERAL INFORMATION

Name: ____
(Last) (First) (Middle)

Responsible Party: ____
(Last) (First) (Middle)

Address: ____
(Street) (City) (State) (Zip Code)

Birthdate: __ __ / __ __ / __ __ __ __ Social Security Number (SSN): ______-______-______

Age: ______

Sex:
____Male
____Female

Marital Status:
____Divorced
____Legally Separated
____Married
____Single
____Widowed

Race: (please check one)
____ African American
____ Asian
____ Hispanic or Latino
____ Pacific Islander
____ White
____ Other

Ethnicity: (please check one)
____ Hispanic or Latino
____ Not Hispanic or Latino

Employer: ________________________________Phone Number: ____________________

Who Referred you to Healthways? ____

CONTACT INFORMATION

Home Phone: (___) _______-_______ would you like a text or email reminder? Y/N

Work Phone: (___) _______-________ Signature: ______________________
Cell Phone: (___) _______-_________

Email Address: ____

CIRCLE ALL ALLERGIES:

Ace Inhibitors	Animal Hair	Antihistamines	Bee Sting
Cat Hair	Cephalosporin	Dog Hair	Egg/Poultry
Environmental Allergy	Fish Product Derivatives	Gluten Protein	Influenza Virus Vaccines
Lactose	Latex	Levodopa	Macrolides
Milk Products	Mumps vaccine	Niacin	NSAIDS
Peanut	Penicillin	Pollen	Quinolones
Ragweed	Salicylates	Shellfish	St. John's Ward
Sulfa (Sulfonamide Antibiotics)	Tetanus Toxoid	Tetracycline	Tricyclic Compounds
Vitamin C	Watermelon		

Other: ____

Please list all Medications and any Supplements you are taking:

Name of Medication or supplement and Dosage:

____

____

____

____

____

____

____

____

Please Indicate If Maternal Grandma (MGM), Maternal Grandpa (MGF), Paternal Grandma (PGM),

Paternal Grandpa (PGF), Mother (M), Father (F), Brother (B), Sister (S) Also if Alive (A) Deceased (D) :

Anemia			Anxiety			Arthritis			Asthma		
BPH			Back Problem			Breast Ca			CAD		
CHF			COPD			Cancer			Cholesterol High		
Dementia			Depression			Dermatitis			Diabetes		
Epilepsy			GERD			Glaucoma			Gout		
HIV			Headache			Hepatitis			Hypertension		
MI			Migraine			Pneumonia			Renal Stone		
Stroke			TB			Thyroid Disease			Ulcer (GI)		

Any Family History of the Following Cancers:

If yes who and what age when diagnosed if known:

Y / N Breast Cancer:____

Y / N Uterine Cancer: ____

Y / N Ovarian Cancer:____

Y / N Colorectal Cancer:____

Females ONLY:

Last Menstrual Cycle:__________________________

Menopausal Status: __________________________

Gravida - # of Pregnancies:__________________________

Para # of Births after 20 weeks:__________________________

# of Miscarriages or Abortions: __________________________

Social History:

Do you smoke? Yes No

Have you ever smoked? Yes No

Cigarettes Cigars Chew Tobacco Dipping Tobacco

How many per day?__________ How many Years?__________ Last used?__________

Do you drink alcohol? Yes No

Beer Wine Hard Alcohol

How much per day?__________ Years Used __________ Last used __________

Do you Drink Caffeine? Yes No

How much each day?__________

Do you use illicit drugs? Yes No

Have you ever used illicit drugs? Yes No

Do you Exercise? Yes No

If yes how often? ______________________________

CIRCLE ALL SURGERIES:

AAA Repair	Aortic Aneurysm	Appendectomy	Breast Augment
Breast Reduction	CABG	Carotid Endarterectomy	Cataract Extract
Cesarean Section	Cholecystectomy	Colectomy	Duodenal Ulcer
ESWL	Ectopic Pregnancy	Fracture	Gall Bladder
Gastric Banding	Heart Valve	Hernia Abdominal	Hip Fracture
Hip Surgery	Hysterectomy	Intestinal By-Pass	Knee Arthroscopy
Knee Surgery	LS Spine Surgery	Lasik	Mastectomy
Oophorectomy Uni	PTCA	PVD Procedure	Pacemaker
Prior Surgeries	Prostate Biopsy	Prostatectomy Retro	Should. Arthroscopy
Shoulder Surgery	Synovectomy (Nasal)	Splenectomy	TURP
Thyroidectomy	Tonsillectomy	Tubal Ligation	Vasectomy

Other_____________

CIRCLE ALL PAST MEDICAL HISTORY CONDITIONS:

Anemia	Anxiety	Arthritis	Asthma
BPH	Back Problem	Breast Cancer	CAD
CHF	COPD	Cancer	Cholesterol High
Dementia	Depression	Dermatitis	Diabetes
Epilepsy	GERD	Glaucoma	Gout
HIV	Headache	Hepatitis	Hypertension
MI	Migraine	Pneumonia	Renal Stone
Stroke	TB	Thyroid Disease	Ulcer (GI)

Other:____

Healthways Medication History Authorization

I, ____(Print patient Name), authorize Healthways PLLC to access my medication history; if available through Meditouch software to be added to my Healthways Chart.

Patient or Guardian Signature:____

Date:_______________________________

Privacy Policy

The following page is the last page of the Healthways patient privacy policy. Please sign and date the bottom of the form. If you would like to receive the full copy of this privacy policy, the receptionists will be happy to print you a copy. The full copy of the privacy policy is located in the waiting room, as well as on our website.

Thank you.