We Care Mobile Health Services Medical History

First Name: ___________ Middle Name: ____________Last Name:______________
Date of Birth: Month:____ Day: _____ Year: ______ SSN:____________________
Height:_______ Weight: __________ Ethnic Group:____________________
Primary Language: _______________ Secondary Lanuage:______________________
Sex: Male:_____ Female: _____

Insurance Information

Primary Medical Insurance Company:____
Group Policy Number: ____________ Identification Number: ___________________________
Insurance Address: ____
Insurance Phone Number: __________________________
Coverage Date: __________________________

Secondary Insurance:____
Group Policy Number :_____________Identification Number: __________________________
Insurance Address: ____
Insurance Phone Number: __________________________
Coverage Date: __________________________

Primary Physician Practice Name:____
Primary Physician Name: ____
Primary Physician Phone: ________________________

Allergies to Medication or Food, Please list all allergies:

________________________ ________________________
________________________ ________________________
________________________ ________________________

Tobacco Products: Yes: ____ No: ____
If Yes: Type? Years of Use: ____

Alcohol Use: Yes:___ No: ___

If Yes, Type? How Often?: ____

Medications:

Name	Dose	How Often

Chronic Conditions: Please list all conditions (Hypertension, Diabetes, Allergies, Gastrointestinal, etc) you have been diagnosed with in the past

________________________ ________________________

________________________ ________________________

________________________ ________________________

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Prior Surgeries: Please List all surgeries in past and include date

Date	Surgery

Family History List Who has the following diseases

Cardiac: Including Hypertension, Heart Attack:

___

Diabetes:

___

High Cholesterol:

___

Cancer Include Type:

___