Wamego Family Clinic
BETTER HEALTH. BETTER COMMUNITY.

Health History Today's Date:

Patient Name:		Birth Date:
Language:	Race:	Indicate the following: Hispanic or Not Hispanic

Assigned sex at birth:	Gender identity (Person's internal sense of self):	Social Security Number:

Address:	Phone:

Email Address: **Do you want access to the Patient Portal for Wamego Family Clinic?** Yes____ No____

Preferred Pharmacy:

Preferred Lab Location:	Preferred Radiology Location:

Present Health Concern:

Are you disabled?
Explain:

Do you have advance directives?
(Example: Living Will or DNR. If yes, please provide a copy to office.)

Do you have a medical power of attorney?
(If yes, please provide a copy to office.)

Allergies:
(Indicate the type of reaction to Food, medications, other, or indicate "None".)

Current Medications or indicate "None": (List additional on back)

Name	Strength	Frequency	Name	Strength	Frequency
1			5		
2			6		
3			7		
4			8		

Current Specialists:
(Example: Optomotrist, Cardiologist, Physical Therapy, Mental Health, etc.)

Surgeries/Date: (List additional on back)
1 2 3

Hospitalizations/Date: (Within last 2 years - List additional on back)
1 2 3

Medical Implants/Date:				
1	2	3		
Home Medical Equipment Used:				
Date/Location of Last Colonoscopy:		Results Normal:	Yes____	No____
Date/Location of Last Echocardiogram:		Results Normal:	Yes____	No____
Date/Location of Last Cardiac Stress Test:		Results Normal:	Yes____	No____
Date/Location of Last Eye Exam:		Results Normal:	Yes____	No____
Date/Location of Last Dental Exam:		Results Normal:	Yes____	No____

Men Only:		
Date PSA Checked:		None:_____
PSA Normal:	Yes_____	No_____
Date of Prostate Exam:		None:_____
Prostate Normal:	Yes_____	No_____
Date of Vasectomy:		None:_____
Testicles / Scrotum:		
Swelling or Tender	Yes_____	No_____

Women Only:		
Last Period Date:		None:_____
Regular Periods:	Yes____	No____
Last Pap Smear Date:		None:_____
Pap Smear Normal:	Yes____	No____
Last Mammogram Date:		None:_____
Mammogram Normal:	Yes____	No____
Last Dexa Scan Date:		None:_____
Dexa Scan Normal:	Yes____	No____
Number of Pregnancies:		
Number/Type of Deliveries:		

Self and Family History:

Please indicate self, mom, dad, brother, sister, son, daughter, paternal grandma/grandpa, maternal grandma/grandpa.

	Self	Other Relations		Self	Other Relations
Glaucoma			Ulcer		
Asthma			Diabetes		
COPD/Bronchitis			Thyroid Disorder		
Emphysema			Arthritis		
Heart Disease			Osteoporosis		
High Blood Pressure			Migraines		
DVT/Phlebitis (clots)			Rheumatic Fever		
Pneumonia			Epilepsy		
Stroke			Alcohol/Drug Addictio		
Tuberculosis			STD		
Anemia			Depression		
Bleeding Problems			Anxiety		
Celiac			Dementia		
Kidney/Bladder/ Urinary Tract Infections			Mental Health Conditions		
Colitis			Cancer (Type)		
Liver Disease					
Hepatitis			Other:		
Other:			Other:		

Immunizations: Mark all that have been received. List dates if known.

Tetanus (Td)		Hepatitis A	
-with Pertussis (Tdap)		Hepatitis B	
Varicella-Chicken Pox		MMR	
Influenza-Flu shot		Meningitis	
Pneumovax		Zostavax-Shingles	
Covid		HPV	
Tb Test	Results:	Other:	

Social Information:

Occupation:		Number of hours worked each week:
Marital Status:		
Describe your housing situation and who lives with you.		
Diet:		
Explain if you follow a specific diet or have food restrictions?		
Tobacco Types:		None:_____
Amount-	How long have you used tobacco?	Would you consider quitting?
Alcohol Types:		None:_____
Amount-	How long have you used alcohol?	Would you consider quitting?
Illicit Drug Types:		None:_____
Amount-	How long have you used ellicit drugs?	Would you consider quitting?
Caffeine Types:		None:_____
Amount-		
Exercise Types:		None:_____
Explain type, frequency, duration.		
Weight Management:		
Do you need to gain or lose weight?		Would you consider assistance?

Primary Insurance Company Name:	Name on Insurance Card
Policy Holder	Policy Holder's Date of Birth:
Member ID Number:	Group ID Number:
Secondary Insurance Company Name:	Name on Insurance Card
Policy Holder	Policy Holder's Date of Birth:
Member ID Number:	Group ID Number:

The above information is complete and accurate to the best of my knowledge.

Patient/Guardian Signature: _____ **Relation:** _____ **Date:** _____