THE HICKEY WELLNESS CENTER

DATE OF LAST PHYSICAL EXAM:	NAME:			1					
DATE OF BIRTH: Date of Birth:	NAME.			II DATE C	AF LACT DUVCTCAL EVAM.				
ADDRESS: DATE OF BIRTH: Diabetes	OCCUPATION:			DATE OF LAST PHYSICAL EXAM:					
DATE OF BIRTH: Please list any medication allergies or reactions: Diabetes	ADDRECC:			LIST AN	Y SYMPTOMS YOU ARE CURREN	ITLY HAVING:			
MEDICAL HISTORY Please list any medication allergies or reactions: Diabetes	ADDICESS.								
MEDICAL HISTORY Please list any medication allergies or reactions: Diabetes									
Please list any medication allergies or reactions: Please check to indicate if you have ever had the following conditions:	DATE OF B	BIRTH:							
Please list any medication allergies or reactions: Please check to indicate if you have ever had the following conditions:									
Please list any medication allergies or reactions: Please check to indicate if you have ever had the following conditions:	MEDI	CAL HIST	ORV						
Diabetes Congestive Heart Failure Kidney Disease Emphysema Stroke Heart Attack Tuberculosis High Cholesterol Seizures Migh Blood Pressure Measles Hepatitis German Measles Depression Mumps Coronary Artery Chicken Pox Disease Diphtheria Pneumonia Influenza Arthritis/Rheumatism Anemia Liver Disease Gallbladder surgery Sexually Trans. Migraine Headaches Disease Disease Migraine Headaches Disease Disease Migraine Headaches Disease Disease Migraine Headaches Disease Cancer-Type MENSTRUAL HISTORY PREGNANCIES Age at onset How many Complications Y N Divation (Days) Live Births How many Complications Y N Divation (Days) Live Births Heavy Miscarriages C-sections Light Cramping Y N Complications Cancer-Tipe Light Cramping Y N Cancer-Tipe Light Cramping Y N Cancer-Tipe Light Cramping Y N Live Births Light Cramping Y N Live Births Light Cramping Y N Light Cramping Y									
Diabetes Congestive Heart Failure Kidney Disease Emphysema Stroke Heart Attack Tuberculosis High Cholesterol Seizures Migh Blood Pressure Measles Hepatitis German Measles Depression Mumps Coronary Artery Chicken Pox Disease Diphtheria Pneumonia Influenza Arthritis/Rheumatism Anemia Liver Disease Gallbladder surgery Sexually Trans. Migraine Headaches Disease Disease Migraine Headaches Disease Disease Migraine Headaches Disease Disease Migraine Headaches Disease Cancer-Type MENSTRUAL HISTORY PREGNANCIES Age at onset How many Complications Y N Divation (Days) Live Births How many Complications Y N Divation (Days) Live Births Heavy Miscarriages C-sections Light Cramping Y N Complications Cancer-Tipe Light Cramping Y N Cancer-Tipe Light Cramping Y N Cancer-Tipe Light Cramping Y N Live Births Light Cramping Y N Live Births Light Cramping Y N Light Cramping Y									
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Kidney Disease		-							
Stroke			-	railuie	List any surgeries or hospitalizations:				
Tuberculosis		*	· ·		Туре	Date/year			
Arrhythmia									
Hepatitis		Arrhythmia							
□ Depression □ Mumps □ Coronary Artery □ Chicken Pox □ Disease □ Diphtheria □ Pneumonia □ Influenza □ Arthritis/Rheumatism □ Anemia □ Liver Disease □ Gallbladder surgery □ Sexually Trans. □ Migraine Headaches Disease □ Migraine Headaches □ Cancer- Type MENSTRUAL HISTORY PREGNANCIES Age at onset □ How many □ Complications Y N Duration (Days) □ Live Births □ Flow: □ Heavy Miscarriages □ Med □ Light □ Light C-sections □ Light Cramping Y N □ Cramping Y N □ Cramping Y N			☐ Measles						
Coronary Artery Disease Thyroid Disease Diphtheria Pneumonia Influenza Arthritis/Rheumatism Anemia Liver Disease Gallbladder surgery Sexually Trans. Disease Cancer- Type Eye Problems-Type Have you every had contrast dye with an MRI? Y N LIST OTHER DISEASES Chicken Pox Diphtheria Di		Hepatitis	☐ German Measles						
Disease Thyroid Disease Diphtheria Pneumonia Influenza Arthritis/Rheumatism Anemia Liver Disease Gallbladder surgery Sexually Trans. Disease Cancer- Type Eye Problems-Type Have you every had contrast dye with an MRI? Y N LIST OTHER DISEASES Diphtheria Diphtheria Influenza Anemia (WOMEN ONLY) MENSTRUAL HISTORY PREGNANCIES Age at onset Periods Regular Y N Complications Y N Duration (Days) I Live Births Flow: Heavy Miscarriages Med C-sections Light Cramping Y N		Depression	☐ Mumps						
□ Thyroid Disease □ Diphtheria □ Pneumonia □ Influenza □ Liver Disease □ Gallbladder surgery □ Sexually Trans. □ Migraine Headaches □ Disease □ Cancer- Type □ Eye Problems-Type		Coronary Artery	☐ Chicken Pox						
□ Pneumonia □ Influenza □ Arthritis/Rheumatism □ Anemia □ Liver Disease □ Gallbladder surgery □ Sexually Trans. □ Migraine Headaches Disease Migraine Headaches □ Cancer- Type MENSTRUAL HISTORY □ Eye Problems-Type How many — Periods Regular Y N Complications Y N Duration (Days) Live Births Flow:Heavy Miscarriages — Med C-sections LIST OTHER DISEASES Cramping Y N									
Arthritis/Rheumatism			· · · · · · · · · · · · · · · · · · ·						
Liver Disease									
Sexually Trans. Migraine Headaches									
Cancer- Type (WOMEN ONLY)									
MENSTRUAL HISTORY PREGNANCIES			☐ Migraine Headach	nes					
Age at onset How many Complications Y N Duration (Days) Have you every had contrast dye with an MRI? Y N Live Births Miscarriages Med Light		Cancer- Type			(WOMEN ONLY)				
Have you every had contrast dye with an MRI? Y N LIST OTHER DISEASES Periods Regular Y N Duration (Days) Flow: Heavy Miscarriages C-sections Cramping Y N Complications Y N Duration (Days) Live Births Miscarriages C-sections Cramping Y N					MENSTRUAL HISTORY	PREGNANCIES			
Have you every had contrast dye with an MRI? Y N Duration (Days) Live Births Miscarriages C-sections LIST OTHER DISEASES Cramping Y N		Eye Problems-Type							
LIST OTHER DISEASES LIST OTHER DISEASES Cramping Y N	Have yo	ou every had contrast o	dye with an MRI? Y	N	Flow: Heavy	Live Births Miscarriages			
						C-sections			
	LIST OTHER DISEASES				Cramping Y N				

FAMILY MEDICAL HISTORY

FAMILY HISTORY	AGE	HEALTH	HAS ANY BLOOD RELATIVE EVER HAD RELATIONSHIP				
FATHER			CANCER	Υ			
MOTHER			TUBERCULOSIS	Υ	N		
BROTHERS/SISTERS			DIABETES	Υ	N		
			HEART PROBLEMS	Υ	N		
			HIGH BP	Υ	N		
			STROKE	Υ	N		
SPOUSE			SEIZURES	Υ	N		
SONS/DAUGHTERS			MENTAL ILLNESS	Υ	N		
			SUICIDE	Υ	N		
			ADDICTIONS	Υ	N		
HEALTH HABIT	<u>ΓS</u>						
	es each day	co products?	Yes No	0		Quit	
Do you drink alcohol How much? How often?			Yes N	lo		Quit	
ANY ADDITIONAL HE	ALTH ISS	SUES OR CONCERNS:					