THE HICKEY WELLNESS CENTER

NAME:	DATE OF LAST PHYSICAL EXAM: ______________________
OCCUPATION:	LIST ANY SYMPTOMS YOU ARE CURRENTLY HAVING:
ADDRESS:	____
DATE OF BIRTH:	____
	____

MEDICAL HISTORY

Please list any medication allergies or reactions:

____

____

Please check to indicate if you have ever had the following conditions:

☐	**Diabetes**	☐	**Congestive Heart Failure**
☐	**Kidney Disease**	☐	**Emphysema**
☐	**Stroke**	☐	**Heart Attack**
☐	**Tuberculosis**	☐	**High Cholesterol**
☐	**Arrhythmia**	☐	**Seizures**
☐	**High Blood Pressure**	☐	**Measles**
☐	**Hepatitis**	☐	**German Measles**
☐	**Depression**	☐	**Mumps**
☐	**Coronary Artery Disease**	☐	**Chicken Pox**
☐	**Thyroid Disease**	☐	**Diphtheria**
☐	**Pneumonia**	☐	**Influenza**
☐	**Arthritis/Rheumatism**	☐	**Anemia**
☐	**Liver Disease**	☐	**Gallbladder surgery**
☐	**Sexually Trans. Disease**	☐	**Migraine Headaches**

List any surgeries or hospitalizations:

Type	*Date/year*

☐ **Cancer- Type**

____

☐ **Eye Problems-Type**

____

Have you every had contrast dye with an MRI? Y N

LIST OTHER DISEASES

____

____

(WOMEN ONLY)

MENSTRUAL HISTORY	**PREGNANCIES**
Age at onset _________	How many ____________
Periods Regular Y N	Complications Y N
Duration (Days) _____	Live Births ________
Flow: ___ Heavy	Miscarriages ________
____Med	C-sections ________
____Light	
Cramping Y N	
Age last period ______	

FAMILY MEDICAL HISTORY

FAMILY HISTORY	AGE	HEALTH	HAS ANY BLOOD RELATIVE EVER HAD…. RELATIONSHIP
FATHER			CANCER Y N
MOTHER			TUBERCULOSIS Y N
BROTHERS/SISTERS			DIABETES Y N
			HEART PROBLEMS Y N
			HIGH BP Y N
			STROKE Y N
SPOUSE			SEIZURES Y N
SONS/DAUGHTERS			MENTAL ILLNESS Y N
			SUICIDE Y N
			ADDICTIONS Y N

HEALTH HABITS

Do you smoke or use any tobacco products?...Yes No Quit

Number of cigarettes each day? _______________

How many years? _______________

Other forms of tobacco use? _______________

Do you drink alcohol? …………………………………………………………………………………………………… Yes No Quit

How much? _________________________

How often? _________________________

ANY ADDITIONAL HEALTH ISSUES OR CONCERNS:

____

____

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