Bartels Medical Associates, PLLC

Medical Weight Control

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DATE:_____

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

ADDRESS:_____ CITY:_____ STATE & ZIP CODE:_____

DATE OF BIRTH:_____ OCCUPATION:_____

PHONE NUMBERS:_____ (HOME) ARE YOU CURRENTLY ON MEDICARE OR MEDICAID? YES NO
_____ (WORK) LIVES WITH:_____
_____(CELL) (EXAMPLE: WIFE, HUSBAND, SON, ALONE, ETC)
OK TO LEAVE MESSAGE AT HOME? Y N

LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING OR THAT YOU USUALLY TAKE. INCLUDE ALL PRESCRIPTIONS FROM OTHER PHYSICIANS AND ALL MEDICATIONS BOUGHT WITHOUT A PRESCRIPTION; SUCH AS ANACIDS, LAXATIVES, AND PAIN MEDICATIONS SUCH AS ASPIRIN. PLEASE LIST THE DOSAGE AND FREQUENCY USED (EXAMPLE: ASPIRIN, 5 GRAINS, TWO TABLETS EVERY FOUR HOURS)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

DO YOU HAVE DRUG OR FOOD ALLERGIES?
YES NO
IF THE ANSWER IS YES, PLEASE LIST THEM BELOW:__

_____
_____
_____
_____
_____
_____

DO YOU SMOKE? YES NO NUMBER/DAY.

DO YOU DRINK ALCOHOL? YES NO AMOUNT_____

Please list any serious medical and surgical illnesses that you have had.

MAJOR MEDICAL ILLNESSES (List the onset. This should include such things as high blood pressure, cancer, pneumonia, diabetes, heart disease, asthma and others.)

1. _____ Date_____ Doctor_____
2. _____ Date_____ Doctor_____
3. _____ Date_____ Doctor_____
4. _____ Date_____ Doctor_____

IMMUNIZATIONS:

Adult	Date
Pneumonia	_____
Flu Vaccine	_____
Tetanus	_____
Other_____	_____
_____	_____

HOSPITALIZATIONS and SURGERIES List the times that you have been in the hospital, either for a medical problem or for surgery.

_____ Date_____ Doctor_____

_____ Date_____ Doctor_____

_____ Date_____ Doctor_____

_____ Date_____ Doctor_____

_____ Date_____ Doctor_____

List Diagnostic procedures such as Pap Tests, Mammograms, Colonoscopies, etc.

_____ Date_____ Doctor_____

_____ Date_____ Doctor_____

_____ Date_____ Doctor_____

Date of last complete physical examination Date_____ Doctor_____

Please give us your family history of various problems, such as diabetes, heart trouble, high blood pressure, stroke, cancer, bleeding diseases, tuberculosis, gout, arthritis, kidney disease, convulsive disorder, suicide or other problems.

Father: If living, give age ( ) health problems_____
If dead, give age at death ( ) cause_____

Mother: If living, give age ( ) health problems_____
If dead, give age at death ( ) cause _____

Siblings: Total Living ( ) Total Dead ( ) Cause of death_____
List any health problems_____

Children: Total _____ Ages_____ Illnesses_____