# Pensacola Wellness Solutions- Patient Registration

Last Name: First: Middle:

_____

Gender: Male Female Date of Birth: _____/_____/_____

Email: _____@_____

Marital Status: Single: ___ Divorced: ___ Married: ___ Divorced: ___

Widow(ed): ___ Partner: ___

**May We**

Call You? Yes ___ No___

Email You? Yes___ No___

Send You Mail? Yes__ No___

Address:

_____

City: State: Zip:

_____

Home Phone: Cell: Work:

(____)_____(____)_____(____)_____

Occupation: Employer:

How did you hear about Pensacola Wellness Solutions?

Bill Board: ____ Internet: _____ Newspaper: ____ Phone Book: ____ Walk In: ____ Radio: ____

TV: ____ Patient/Friend: _____

**Consent**

Would you like to be enrolled in our patient portal that allows you to access your Personal Health Records? (PHR) Yes: __ No__

Name an individual authorized to pick up medical records on your behalf:

_____

**Emergency Contact**

Local Friend/Relative Relationship Contact Number

_____(____)_____

Name: _____ DOB: _____

**Personal Health History**

Are you under a doctor's care at the present time? Yes: ___ No: ___ If Yes, please explain:

_____

Personal Medical History: ( Please check)

| | | |
|---|---|---|
| Diabetes ____ | Hepatitis/Liver Disease ____ | Anxiety ____ |
| Hypertension ____ | High Cholesterol _____ | Back Pain ____ |
| Heart Murmur ____ | Kidney Disease ____ | Thyroid Disorder ____ |
| Mitral Valve Prolapse ____ | Cancer _____ | Bleeding Disorder ____ |
| Heart Disease ____ | Depression _____ | Osteoporosis _____ |

List any disorders not listed above and explain:

_____

Have you had a bone density test (Dexa Scan)? Yes / No

Do you have complexion issues such as oily skin or acne? Yes/ No

Do you have blood clotting issues? Yes / No

Tobacco Use: Yes / No How many packs per day? _____ How many years? _____

How many alcoholic drinks weekly? _____

**Family History**

Is there a family history of Heart Disease? Yes ____ No ____

Relationship: _____ _____ _____

Is there a family history of cancer? Yes _____ No _____

Relationship: _____ _____ _____

**Medication Allergies**

**Medication Name:** **Reaction**

_____

_____

**Medications**

***Please list all Medications and over the counter supplements ( include vitamins and inhalers, etc)***

Medication Name Dosage Frequency

_____

_____

_____

_____

Name: _____ DOB: _____

**Surgeries and Other Hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please check any symptoms you are currently experiencing**

**Review of Symptoms**

| | | | |
|---|---|---|---|
| Insomnia | ____ | Fatigue | ____ |
| Short term memory loss | ____ | Weight Gain | ____ |
| Hot Flashes | ____ | Decreased Sex Drive | ____ |
| Night Sweats | ____ | Difficulty Climaxing | ____ |
| Headaches | ____ | Loss of Muscle Mass | ____ |
| Depression | ____ | Breast Enlargement | ____ |
| Irritability | ____ | Bladder Symptoms | ____ |
| Nervousness | ____ | Hair Loss | ____ |

**OB/GYN History Female Patients Only**

Age at first menses: _____ Are you still menstruating? Y / N

Date of Last Menstrual Period: _____ Are your periods Regular? Y / N

Have you had a hysterectomy? Y / N Date: _____ Last Pap Smear: _____

Last Mammogram: Date/Results: _____

Please list any other concerns you may be having: _____

_____

**I hearby agree that the information contained in this medical history is accurate to the best of my knowledge.**

**Print Name:** _____ **Date:** _____

**Signature:** _____