COMMUNITY HEALTH & WELLNESS PARTNERS
Care... To Live Life Fully

Patient Medical Information

Pharmacy:_____

What are your Top 3 goals for your first appointment?
1.) _____
2.) _____
3.) _____

HEALTH HISTORY:
Please check any condition you have been diagnosed with by a medical professional.

☐	AIDS/HIV	☐	Environmental allergies to:	☐	TIA
☐	Alcoholism			☐	Tuberculosis
☐	Anemia	☐	Epilepsy/Seizures	☐	
☐	Osteoarthritis of:	☐	Glaucoma	☐	Depression
☐	Asthma	☐	Heart Disease	☐	Anxiety
☐	Birth Defects	☐	Hyper cholesterol	☐	ADHD
☐	Bleeding Disorder: (type if known):	☐	Hypertension	☐	Bipolar Disorder
		☐	Thyroid: Hyper or Hydro	☐	Borderline Personality
☐	Cancer of:	☐	Gestational Diabetes	☐	Schizophrenia
☐	COPD	☐	Kidney Disease	☐	OTHER:
☐	Dementia: (type if known):	☐	Liver Disorder	☐	
		☐	Migraine	☐	
☐	Diabetes: Type 1 or Type 2	☐	Stroke	☐	

SURGICAL HISTORY:

Date	**Type of Surgery**	**Hospital/Location**

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Medications:

Please list ALL medications, vitamins, supplements that you are currently taking. Please bring medications.

Medication Name	Dosage (mg)	How often taking per day

Family History:

Please check the box if a family member diagnosed with that condition. For cancers, please indicate the type.

Condition	Mother	Father
Alcoholism		
Dementia		
Anemia		
Asthma		
Birth defects		
Bleeding disorder		
Cancer:		
Diabetes		
Heart disease		
High cholesterol		
Stroke		
Heart attack		
Migraine		
Epilepsy		
Glaucoma		
Thyroid issues		
Suicide		
Tuberculosis		