Care on Wheels Inc.

Patient Information

Name _____ Date _____
Last First MI

Date of Birth ___/___/_____ Age _____ Social Security No. ___-___-_____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Fax _____ Appointment Reminders to: Cell: ☐ E-mail: ☐ Home Phone: ☐

E-mail _____

Race _____ Ethnic Group _____ Language Spoken _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Sex: Male ☐ Female ☐

Employer Name _____ Position _____

Spouse's Name _____ Spouse's Work Phone _____

Pharmacies Used _____

Phone No. _____ Fax No. _____

Pharmacies Used _____

Phone No. _____ Fax No. _____

Emergency Contact

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

OFFICE USE ONLY

ACCT NO _____ START DATE _____

Care on Wheels Inc.

Patient Name _____ Date _____

Please list the following information:

(1) Any conditions or chronic illnesses (i.e. high blood pressure, diabetes, pregnancy, glaucoma, etc.) _____

(2) Any Major Surgeries you have had, the dates of the surgery, and the doctor performing surgery (if known) _____

(3) All prescription medications being taken (i.e. medications taken for chronic conditions, birth control, etc.) _____

(4) All non-prescription medications (i.e. aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins, etc.) _____

(5) All allergies to medications _____

(6) All past hospitalizations _____

(7) Individuals you live with and their ages _____

Date of Last Mammogram _____ **Living Will** Yes or No

Date of Last Colonoscopy _____

Date of Last Glaucoma Check _____

Vaccinations/Injections

__Tetanus	_____Date	__Hepatitis B	_____Date
__Pneumonia	_____Date	__Flu	_____Date
__Measles	_____Date	__Shingles	_____Date
__Hormone	_____Date	__Other_____	_____Date
__Hepatitis A	_____Date		

Care on Wheels Inc.

Family History

	YES	NO	If Yes, Family Member
Breast Cancer	☐	☐	_____
Colon Cancer	☐	☐	_____
Prostate Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____
Hypertension	☐	☐	_____

Do you smoke? Yes ☐ No ☐ Used To ☐

If yes, how much? _____
If used to, how much? _____
How long did you smoke? _____
When did you quit? _____

Do you drink alcoholic beverages? Often ☐ Sometimes ☐ Never ☐

How many drinks a week? _____

Any history of drug use? Yes ☐ No ☐

Do you exercise? Yes ☐ No ☐

If yes, how many times per week? _____

Do you drink caffeinated beverages? Yes ☐ No ☐

If yes, how many drinks per week? _____

Are you sexually active? Yes ☐ No ☐

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