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**WYOMING MEDICAL WELLNESS CENTER, P.C.**

**Screening Questionnaire**

**Date: \_\_\_\_\_\_\_\_\_\_**

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle one: Male or Female Marital Status: \_\_\_\_\_\_**

**In case of emergency, contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy holder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies or Drug Reactions** (list drug and reaction):

 Please list your main reason for making an appointment:

What are your healthcare goals?

Please list your current medical problems: (list the conditions you are currently being treated for)

Please list other doctors who are also currently treating you or have treated you in the past 3 years:

**Past medical history**: Please list all hospitalizations, major illnesses and surgeries:

**Past medical history:** Please place an ‘X’ whether you have ever had the following:

|  |  |  |
| --- | --- | --- |
| Hypertension | Diabetes | Heart murmur |
| Heart problems | Asthma | COPD |
| Tuberculosis | Emphysema | Ulcers |
| Colon polyps | Gall bladder problems | Hepatitis or Jaundice |
| Cancer | Arthritis | Thyroid problems |
| Liver problems | Pancreatitis | Kidney problems |
| Seizure | Depression/Anxiety | Stroke |
| Blood problems | Blood Clots | Other (please explain) |

**Current Medications:**

\*\***Please list all the medications you are taking, including over-the-counter medications, vitamins, herbs, and other treatments\*\***

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| Name of medication | Prescribed by | Purpose | Refills needed? |
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Referred by/how did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_