

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:

<u>Adult</u>	<u>Date</u>
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 _____