BRONSON

☐ **ProHealth - Battle Creek**
☐ **ProHealth - Elm Valley Dr**
☐ **ProHealth - John St.**
☐ **ProHealth - Paw Paw**

Affix Patient Label

Patient Name: DOB:

PATIENT DEMOGRAPHIC INFORMATION

EMPLOYER INFORMATION

Employer /Site:_____ Address:_____
Contact Person:_____ Work Phone:_____
Job Title: _____ Shift worked:_____

PATIENT INFORMATION

Address:_____ City:_____ State:_____
Zip Code:_____
Home Phone:_____ Cell Phone:_____ Soc#:_____
Primary Care Physician:_____ Office/Location:_____
What Pharmacy do you use?_____ Location:_____

What is the reason for you visit today? ☐ Physical ☐ Injury (describe)_____

MEDICATIONS What prescription medications do you take? ☐ None

Name of Medication	What is it for?	How much? How often?	When did you start taking this?

What non-prescription medications do you take? (including Aspirin) ☐ None

Name of Medication	What is it for?	How much? How often?	When did you start taking this?

ALLERGIES Are you allergic to any medicines? ☐ No ☐ Yes, if yes please list medicine and your reaction.
Are you allergic to iodine, shellfish or contrast dye? ☐ No ☐ Yes

Medication	Reaction

PAST SURGICAL HISTORY ☐ None

Type of Surgery?	Surgeon?	What Hospital?	When was it done?

Please flip over and complete other side of this form.

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HOSPITALIZATIONS Have you been hospitalized for reasons other than the above surgeries? ☐ Yes ☐ No

Date?	Reason for hospital stay?

PAST MEDICAL HISTORY Have you been diagnosed with any other medical problem?

☐ None Check all that apply:

☐ High blood pressure	☐ Fibromyalgia	☐ Aortic Aneurysm	☐ Anxiety Disorder
☐ Back Pain	☐ Brain aneurysm	☐ Poor Circulation	☐ Other mental illness:_____
☐ Diabetes	☐ Migraine Headaches	☐ Depression	☐ Addiction to alcohol/drugs
☐ Cancer	☐ Seizures	☐ Kidney Problems	☐ HIV / AIDS
☐ Osteoarthritis	☐ Tuberculosis	☐ Liver Problems	☐ Major trauma (accidents/falls)
☐ Joint Pain/Gout	☐ Emphysema or Asthma	☐ Bowel problems	☐ Broken bones
☐ Thyroid Disease	☐ Heart Attack or Angina	☐ Easy Bleeding	☐ Prolonged prednisone use
☐ Osteoporosis	☐ Irregular Heartbeat	☐ Blood Clots	☐ OTHER:_____
☐ Stroke or TIA	☐ Abnormal Heart Valve	☐ Ulcers in stomach / intestines	
☐ Rheumatoid Arthritis			

FAMILY HISTORY What diseases do your grandparents, parents, brothers or sisters and children have?

☐ None Who has this? What type? Who has this? What type?

☐ Heart Disease_____ ☐ Stroke_____

☐ Cancer_____ ☐ Diabetes_____

SOCIAL HISTORY

Do you use caffeine? ☐ No, or rarely ☐ Yes, up to _____ cups or cans of soda, tea or coffee daily.

Do you use alcohol? ☐ No, or rarely ☐ Yes, up to _____ drinks a day at most.

Do you smoke? ☐ No ☐ I used to, I quit in_____ ☐ Yes _____ packs per day for _____ years.

Do you chew tobacco? ☐ No ☐ Yes

LIFE STYLE How would you describe your current health? ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Do you have regular hobbies?_____

Are you right or left handed ☐ Right ☐ Left

Could you be pregnant? ☐ No ☐ Yes

DOMESTIC VIOLENCE ASSESSMENT

Do you have a safe place to go when you leave here? ☐ No ☐ Yes

Do you feel physically, emotionally or sexually threatened at work or home? ☐ No ☐ Yes

Patient Signature:_____Date:_____

OFFICE USE ONLY

Provider Signature:_____Date:_____Time:_____