Ascension Medical Group

Kohl's Wellness Center
Medical History

KOHL'S Wellness Center

Name (Last, First, Middle)	Social Security No.	Date of Birth	Age	Sex ☐ M ☐ F	Date of Exam
Home Address	Home Phone No.	Work Phone No.	Cell Phone	Email Address	
Job Title	Department				
Name of Emergency Contact	Address of Emergency Contact	Phone No. of Emergency Contact		Relationship	
Name of Personal Physician (PCP)	Address of Personal Physician	Phone No. of Personal Physician			

☐ Please check this box if you will be using the Wellness Center as your Primary Care

The information in this form will be kept strictly confidential and no identifiable medical information about you will be released without your written authorization, except in cases of a medical emergency or as required by law.

Allergies

Are you allergic to any of the following? ☐ No Known Allergies

☐ Medications? ☐ Foods? ☐ Pollen?

☐ Dust or molds? ☐ Animals? ☐ Latex?

☐ Other?

Please Specify? _____

Please include all prescription meds, over the counter meds, supplements and/or vitamins.

Medications	Dose	Reasons for Use

			M	P				M	P
HEALTH CONDITION	**SELF**	**FAM HX**	**FAMILY MEMBER**		**HEALTH CONDITION**	**SELF**	**FAM HX**	**FAMILY MEMBER**	
Anxiety					**Cardiovascular Disease**				
Depression					**Heart Murmur**				
Mental Illness					**Arrhythmia**				
Alcoholism					**Heart Attack**				
Other Addiction					**High Blood Pressure**				
Migraines					**High Cholesterol**				
Seizures					**Diabetes, Type 1 or 2**				
Head Injury					**Hepatitis**				
Stroke					**Gout**				
Sleep Apnea					**Gallbladder Issues**				
Alzheimer Disease					**Kidney Disease/Stones**				
Anemia					**Thyroid Disease**				
Arthritis					**Cataracts**				
Asthma					**Glaucoma**				
Emphysema					**Cancer, What Kind?**				
Ulcers					**Skin Cancer**				
Acid Reflux					**Back/Disk Problems**				
Sexual Trans. Disease					**Hereditary Disorders**				

☐ **ADOPTED**

For any **Yes** answer, indicate diagnosis, any current limitation.

Surgical History

Surgery Date

Personal History

Do you drink/use caffeine? ☐ Yes ☐ No
What kind/How much? _____

Do you use tobacco? ☐ Yes ☐ No

If Yes,
Packs per day: _____ Years: _____
Type: ☐ Cigarettes ☐ Cigars
☐ Chewing tobacco ☐ Pipes
Have you used tobacco in the past? ☐ Yes ☐ No
If so, when did you quit? _____

Do you want help or information about quitting?
☐ Yes ☐ No

Do you use sunscreen? ☐ Yes ☐ No

Do you wear a seatbelt? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If Yes,
☐ Beer _____ per day _____ per week
☐ Wine _____ per day _____ per week
☐ Liquor _____ per day _____ per week

Do you or have you used recreational drugs? ☐ Yes ☐ No

Do you have any concerns with drugs or alcohol that you would like to discuss? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No
What activities? _____
How often? _____

Occupational History

Are you or have you ever served as a member of the armed forces? ☐ Yes ☐ No

If so, when? _____

What branch? _____

For how long? _____

Are you currently employed? ☐ Yes ☐ No

If yes, do you work full time or part time (circle one)?

If no, are you retired, currently out of work, on medical leave, homemaker, disabled or other (please circle one)?

What is your current marital status? _____

Females only: Are you pregnant? ☐ Yes ☐ No If Yes, how many weeks? _____

What form of birth control do you use? ☐ Condoms ☐ Pill ☐ Monogamy ☐ Abstinence ☐ IUD ☐ Tubal Ligation/Vasectomy ☐ Nuva Ring ☐ Other: _____

HEALTH MAINTENANCE

INFLUENZA VACCINE: Date of last vaccine: _____

TETANUS VACCINE: Date of last vaccine: _____

PNEUMONIA VACCINE: date of last vaccine: _____

COLON CANCER SCREENING:

- Date of last screening _____
- Type of screening _____
- Result of screening: _____ normal _____ abnormal _____
- Facility it was performed at _____

MAMMOGRAM:

- Date of last mammogram _____
- Result of screening: _____ normal _____ abnormal _____
- Facility it was performed at _____

PAP SMEAR:

- Date of last pap smear _____
- Result of screening: _____ normal _____ abnormal _____
- Facility it was performed at _____

I certify that this form was completed by me. I certify that the information on the Medical History form is true, complete and correct.

Patient name (Please print): _____

Signature of Patient or Patient/Guardian: _____

Date: _____