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 **PATIENT INFORMATION**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:----Date: -----

# Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Recreational Drug Use: Current Past Never

Smoking: Currently Past Never Packs/day:\_\_\_\_\_\_\_

 Alcohol: Currently Past Never Drinks/day:

# List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications OTC and vitamins

What pharmacy do you use/prefer? \_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** (please circle all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| ADHD | COPD | High Cholesterol | Peptic Ulcer |
| Alcoholism | Dementia | HIV | Psoriasis |
| Allergies, Seasonal | Depression | Hepatitis | Pulmonary Embolism (PE) |
| Anemia | Diabetes: 1 or 2 | Irritable Bowel Syndrome | Rheumatoid Arthritis |
| Anxiety | Diverticulitis | Kidney Stones | Sciatica |
| Arrhythmia (irregular heart beat) | DVT (blood clot) | Kidney Disease | Seizure Disorder |
| Arthritis | Eczema | Lupus | Sleep Apnea |
| Asthma | Emphysema | Liver Disease | Stroke |
| Bipolar | Gallstones | Macular Degeneragtion | Thyroid Disorder |
| Bladder problems/Incontinence | GERO (acid reflux) | Migraines | Ulcerative Colitis |
| Bleeding problems | Glaucoma | Nosebleeds |  |
| Cancer:  | Heart Disease | Neuropathy |  |
| Carpal Tunnel | Heart Attack (Ml) | Osteopenia/Osteoporosis |  |
| Headaches | Hiatal Hernia | Parkinson's Disease |  |
| Crohn's Disease | High Blood Pressure | Peripheral Vascular Disease |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Last Menstrual Period: | yes *I* no | date: | Normal *I* Abnormal |
| Colonoscopy: | yes *I* no | date: | Normal *I* Abnormal |
| Mammogram: | yes *I* no | date: | Normal *I* Abnormal |
| Dxa (Bone Density): | yes *I* no | date:  | Normal *I* Abnormal |

# Other medical problems not listed above:

Surgical History: Please list all prior surgeries and approximate dates performed.

**FAMILY HISTORY:**

**FATHER:** Living: Age

# Deceased: Age:

Alcoholism COPD/Emphysema Stroke

Anemia

Blood Clot/DVT Arthritis

Blood Cancer Skin Cancer Heart Disease Asthma Depression

High Blood Pressure

Migraines Colon Cancer Lymph Cancer Breast Cancer Kidney Disease Diabetes 1 or 2

Bipolar

High Cholesterol Thyroid disorder Dementia Prostate Cancer Thyroid Cancer

Osteoporosis



**MOTHER:** Living: Age Deceased: Age:

Alcoholism COPD/Emphysema Stroke

Anemia

Blood Clot/DVT Arthritis

Breast Cancer Blood Cancer Heart Disease Asthma Depression

High Blood Pressure

Migraines Colon Cancer Skin Cancer Lymph Cancer Kidney Disease Diabetes 1 or 2

Bipolar

High Cholesterol Thyroid disorder Dementia Ovarian Cancer Thyroid Cancer

Osteoporosis



# Siblings: -----------------------------------

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

Patient signature: ------------------- Date: --------