Mays Medical Wellness Clinic, LLC

Full name:_____Age_____DOB:_____

Social Security #:_____Marital Status:_____Gender: Male or Female

Address:_____City:_____State/Zip:_____

Primary phone #:_____Secondary phone:_____

Email:_____

Occupation:_____Employer:_____

Employer phone number:_____

EMERGENCY CONTACT NAMES:_____Phone:_____

_____Phone:_____

Local pharmacy name/phone #:_____

Mail order pharmacy name/phone:_____

How do you want to be notified of Protected Health Information? MARK ALL THAT APPLY ****

Phone:_____ Voicemail:_____ Email:_____ Patient Portal:_____(must sign up to log in)

Provide names of individuals to whom we may release your Protected Health Information to

1. _____relationship_____Phone:_____
2. _____relationship_____Phone:_____

Primary Insurance Name:_____ Policy Holder:_____

Policy Holder DOB & relationship:_____

Policy number & group number: _____

Secondary Insurance Name: _____Policy Holder:_____

Policy Holder DOB & relationship: _____

Policy number & group number: _____

I, the undersigned, certify that I (or my dependent(s) have insurance coverage as described above & assign directly to MMWC, LLC all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize MMC, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party print & sign: _____Date: _____/_____/_____

Medication History

_____ **NO KNOWN DRUG ALLERGIES**

If you are allergic to any medication, please list the medication and the allergic reaction.

Medication:_____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Please list all the Medications, including over-the-counter meds, you take.

List the Drug NAME, DOSE, & NUMBER times a day you take it

(For example: aspirin 81mg, 1 daily)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Social History

Do you smoke? YES or NO Do you dip/chew tobacco? YES or NO Do you Vape? YES or NO

How many packs per day do you smoke and for how long? _____

If you drink alcohol, how many times a week? _____

How much caffeine do you take in daily? _____

Do you have a Medical Marijuana Card? YES or NO

Please list the approximate date you had the following:

Pap Smear_____Mammogram_____Colonoscopy_____

TDAP vaccine_____ Pneumonia vaccine 1._____ 2. _____

Covid vaccine _____ Other vaccines _____

Are you being treated for any of the following:

- ❑ Atrial Fibrillation
- ❑ Anxiety/Depression
- ❑ HIV/AIDS
- ❑ Anemias
- ❑ Arthritis – Osteo or Rheumatoid
- ❑ Asthma
- ❑ Seasonal allergies
- ❑ Angina/Chest pain
- ❑ Incontinence – Bladder or Bowel
- ❑ History of blood clots
- ❑ BiPolar
- ❑ Bleeding disorders
- ❑ Cancer: type _____
- ❑ Chronic Kidney Disease: Stage 1, 2, 3, 4
- ❑ COPD/Emphysema/Chronic Bronchitis
- ❑ Diabetes – Type 1 or Type 2
- ❑ Diverticulitis
- ❑ Dementia
- ❑ Fatty Liver
- ❑ Genital Herpes/warts
- ❑ Glaucoma
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Heart disease/stents/CABG
- ❑ Migraines

___Lupus

___GERD/reflux

___IBS – diarrhea/constipation

___Gout

___Osteoporosis

___Psoriasis

___Seizure disorder

___Sickle Cell

___History of TIAs or Stroke

___Sleep Apnea, do you use CPAP

___Grave's disease/Hashimoto

___Hepatitis B or C

___Do you have a Pacemaker/AICD

Please list any other health issues you are being treated for.

1.

2.

3.

4.

5.

- ❑ Mitral Valve prolapse
- ❑ Heart Murmur
- ❑ Neuropathy

Please specify your family history of the following (Mother, Father, Siblings, Aunts, Uncles, Grandparents)

- ❑ Heart disease/heart attacks/stroke/High blood pressure _____
- ❑ Diabetes _____
- ❑ High cholesterol _____
- ❑ Cancer – what type? _____
- ❑ Any other family health history not listed _____

Please list all surgeries you have had:

_____

_____

_____