Advanced Family Wellness, PS
1115 West Bay Dr NW, suite 202
Olympia, WA 98502
Phone: (360) 570-8010 /Fax: (360)570-8009

PATIENT MEDICAL HISTORY

Name: ____ ______________ Date: _____________

DOB: ____/ _____/_____ Sex: (M/F) Age: _____ Occupation:____________________________

Pharmacy of choice: ____
Pharmacy Location: ____

Pharmacy #: ( ) ( ) ( ) / **Pharmacy Fax#:** ( ) ( ) ( )

***Important** – Please read our refill policy below regarding approval for refills of expired medications and sign your name where indicated, acknowledging that you have read and agree to abide by our policy.

Patients must be seen prior to refilling medications where there are no available refills left, as your physician needs to know your current health status, review prescriptions you are currently taking, have just started or stopped, and possibly order and/ or review blood work before refills are approved. In some instances, your provider may approve a "one-time" refill of your medication and have you schedule a visit to be seen within 15-30 days for follow-up in order to be prescribed further refills. There will be a $7.00 refill charge for each medication approved for a one-time refill.

***Patient signature:** ____ **Date:** ___________

Alcohol use: (Y/N) How often: (D, W, M, O)
Street Drugs: (Y/N) How often: (D, W, M, O)
Caffeine use: (Y/N) How many cups per day? ___
Do you smoke? (Y/N) How much? __ How long? ___ Have you ever quit smoking? (Y/N)

Family History of Illness or Diseases:
(Circle the appropriate family diseases or illnesses)

Cancer, Thyroid, High Blood Pressure, High Cholesterol, Heart Disease, Diabetes, Asthma, Osteoporosis, Dementia, psychiatric

Other:
____
____
____

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Name: ____ DOB: ______________ DATE: ____________

Past medical problems: (Onset)

____
____
____

Hospitalizations / Date/ Reason:

____
____
____

Vaccinations: Date:
Tetanus (Y/N) ________
Pneumovax (Y/N) ________

Other: _________ ________

Mammogram: ________
Colonoscopy: ________

Allergies: ______________________________
____

Personal Injuries: ______________________
Prostate exam/PSA: ____________________
Pain locations: __________________________

What brings you to our office today? ____

What is your goal in seeking care at this clinic?

____
____

Is there anything else that you would like the physician to know?

____
____