GLORY WELLNESS CENTER & WEIGHT LOSS CLINIC

CURRENT MEDICAL HISTORY

PATIENT NAME_____ DATE_____

Please circle all that apply

Thyroid Disease	Depression	Hepatitis	Heart Disease
Glaucoma/Cataracts	Chest Pain	Heartburn	Cancer / type_____
Asthma	Diabetes	High blood Pressure	Heart Murmur
Emphysema	Seizures	Ulcer	Prostate Disease

Other_____

MEDICATIONS

Name of drugs	Strength & Frequency	Name of drugs	Strength & Frequency
1._____		6._____	
2._____		7._____	
3._____		8._____	
4._____		9._____	
5._____		10._____	

DRUG ALLERGIES (please list reactions)

1._____
2._____
3._____
4._____
5._____

PAST SURGERIES(type and dates)

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

SOCIAL HISTORY

Do you currently smoke? __Yes __No # packs per day?_____ How many years_____

If you quit smoking, how long ago?_____

Do you now or have you ever taken any illicit drugs? __Yes __No

Please list:_____

Do you drink alcohol? __Yes __No # drinks per week?_____

Do you drink caffeine? __Yes __No # drinks per day? _____

How many times a week do you exercise? _____

FAMILY HISTORY

1._____
2._____
3._____
4._____

Date of last menstrual period? _____ Age of menopause:_____

Any concerns or history of domestic or sexual violence? __Yes __No

PREGNANCY HISTORY

Year	Sex	Complications
1._____		
2._____		
3._____		
4._____		

IMMUNIZATIONS(please list year)

Influenza:_____
Pneumovax:_____
Tetanus:_____
Hepatitis B:_____
Other_____

Doctor Signature_____ Patient Signature_____

GLORY WELLNESS CENTER & WEIGHT LOSS CLINIC

REVIEW OF SYSTEM

Patient Name_____Date_____

Circle Yes or No

Respiratory	**Now**	**Past**	**Comments**
Wheezing	Y N	Y N	
Frequent Cough	Y N	Y N	
Shortness of Breath	Y N	Y N	
Other	Y N	Y N	

Cardiovascular	**Now**	**Past**	**Comments**
Chest Pain	Y N	Y N	
Irregular Heartbeats	Y N	Y N	
Swelling in Ankles	Y N	Y N	
Other	Y N	Y N	

Neurological	**Now**	**Past**	**Comments**
Tremors	Y N	Y N	
Dizzy Spells	Y N	Y N	
Numbness/Tingling	Y N	Y N	
Other	Y N	Y N	

Endocrine	**Now**	**Past**	**Comments**
Excessive thirst	Y N	Y N	
Too hot/cold	Y N	Y N	
Tired/sluggish	Y N	Y N	
Other	Y N	Y N	

Gastrointestinal	**Now**	**Past**	**Comments**
Abdominal Pain	Y N	Y N	
Nausea/Vomiting	Y N	Y N	
Indigestion/heartburn	Y N	Y N	
Other	Y N	Y N	

Musculoskeletal	**Now**	**Past**	**Comments**
Bone Pain	Y N	Y N	
Muscle Pain	Y N	Y N	
Joint Pain	Y N	Y N	
Other	Y N	Y N	

Integumentary	**Now**	**Past**	**Comment**
Rush	Y N	Y N	
Lumps or bumps	Y N	Y N	
Moles, skin tags	Y N	Y N	
Other	Y N	Y N	

Eyes	**Now**	**Past**	**Comment**
Double Vision	Y N	Y N	
Glaucoma	Y N	Y N	
Cataracts	Y N	Y N	
Other	Y N	Y N	

Psychologic	**Now**	**Past**	**Comment**
Are you generally happy	Y N	Y N	
Do you feel depressed	Y N	Y N	
Do you feel anxious	Y N	Y N	
Do you feel safe at home	Y N	Y N	

Allergic	**Now**	**Past**	**Comment**
Hay Fever	Y N	Y N	
Drug Allergies	Y N	Y N	
Food	Y N	Y N	
Other	Y N	Y N	

Genitourinary	**Now**	**Past**	**Comment**
Change in Stream	Y N	Y N	
Nocturia	Y N	Y N	
Urinate frequently	Y N	Y N	
Other	Y N	Y N	

Ear/Nose/Throat	**Now**	**Past**	**Comment**
Hearing Change	Y N	Y N	
Sore Throat	Y N	Y N	
Sinus Problems	Y N	Y N	
Other	Y N	Y N	

Hematologic/Lymphatic	**Now**	**Past**	**Comment**
Swollen Glands	Y N	Y N	
Blood clotting problem	Y N	Y N	
Bruising	Y N	Y N	
Other	Y N	Y N	

Sexual History	**Now**	**Past**	**Comment**
Change in Sex Drive	Y N	Y N	
Blood clotting problem	Y N	Y N	
Satisfactory?	Y N	Y N	
Other (i.e. sexual trauma)	Y N	Y N	

Constitutional Symptom	**Now**	**Past**	**Comment**
Weight Change	Y N	Y N	
Chills	Y N	Y N	
Sleep Disorder	Y N	Y N	
Other	Y N	Y N	

Living Will? YES OR NO

Last Exams or Lab	**Please enter date**
Dental:_____	Eye:_____
Pelvic:_____	PAP:_____
Mammogram:_____	PSA:_____
Colonoscopy:_____	Stool:_____
Prostate:_____	Bone Density:_____

Doctor Signature_____

Patient Signature_____

GLORY WELLNESS CENTER & WEIGHT LOSS CLINIC

CONDITIONS OF TREATMENT

Permission for Treatment: Permission is hereby granted for Dr. David Ikudayisi or his staff at Glory Wellness Center & Weight Loss Clinic (collectively, the "Provider") to render the patient named below such medical Treatment as deemed necessary.

Authorization for Release of Information: The Provider (through its employees or contracted copying services) may disclose the patient's medical record and account to:

1. Any person or corporation which is or may be liable for all or any portion of all patient's charges, including but not limited to insurance companies, health care service plans, and workers compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.

2. Any referring physician to ensure continuity of medical care.

FINANCIAL AGREEMENT: (PLEASE INITIAL AND SIGN BELOW)

_____ **Self Paying Patient:** I have been informed that **Glory MedClinic, LLC d/b/a Glory Wellness Center & Weight Loss Clinic** does not have a contract with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this amount.

_____ _____

Print Patient's Name Date

_____ _____

Signature (Patient, Patient Representative) Date

_____ _____

Signature (Financial Responsible Party) Date

_____ _____

Signature (Witness) Date

GLORY WELLNESS CENTER & WEIGHT LOSS CLINIC

Patient Name_____
First Middle Initial Last

Street Address_____

City_____ State_____ Zip Code_____

Phone Numbers: **Cell** _____ E-mail_____

Home_____ Work _____

Social Security Number_____ Marital Status_____

Date Admitted_____/_____/_____ Date of Birth _____/_____/_____ Sex _____

Occupation_____

Nearest Relative_____ Phone_____

Allergies?_____ If so please list _____

_____

Are you on any medications?_____ If so please list _____

_____

Referred by:

Phone Book_____ Walk-in/Sign

Patient/Person_____ Letter/Card

Magazine/Newspaper Ad_____ TV_____

Internet_____ Radio_____

Pharmacy/Doctor/Employee_____