We Care Medical Group, PC
520 Bustleton Pike, Ground floor
Feasterville, PA 19053
Tel: (215) 631-3873
Fax: (215) 631-3899

NAME AGE

ADDRESS

HOME PHONE
WORK PHONE
CELL PHONE

EMAIL ADDRESS
DATE OF BIRTH

PREFERED PHONE TO CONTACT YOU ____________________ MARITAL STATUS ______________

LANGUAGE PREFERECE

EMERGENCY CONTANT NAME AND PHONE

PRIMARY CARE PHISICIAN:
PHONE:
FAX:

YOUR PHARMACY NAME:
ADDRESS:
PHONE:

PLEASE, LIST YOUR PAST / CURRENT MEDICAL PROBLEMS

PREVIOUS HOSPITALIZATIONS AND SURGERIES

ALLERGIES

PLEASE, LIST YOUR CURRENT MEDICATIONS WITH DOSES AND FREQUENCY

PLEASE, LIST ANY MEDICAL PROBLEMS IN FAMILY MEMBERS WITH AGE OF ONSET (HYPERTENSION, DIABETES MELLITUS, CANCER)

MOTHER:
FATHER:
BROTHER/SISTER:
OTHERS:

SMOKING HISTORY?
DO YOU DRINK ALCOHOL? IF YES, HOW OFTEN?
DO YOU EXERCISE? HOW FREQUENT?
HISTORY OF ANY DRUGS USE? MARIJUANA?
YOUR OCCUPATION?
WHO DO YOU LIVE WITH?

FEMALE PATIENTS:

LAST MENSTRUAL PERIOD?
HOW MANY PREGNANCIES DID YOU HAVE?
HOW MANY MISCARRIAGES / ABORTIS DID YOU HAVE?
HOW MANY CHILDREB DO YOU HAVE?
IF MENOPAUSE, HOW MANY YEARS?

I have truthfully answered all questions regarding my medical history to the best of my knowledge. I understand that failing to inform the staff about any medical issues and drug use can lead to complications.

Prior to treatment, Dr. Ivanov reviewed my complete medical history and answered all questions I have regarding the treatment.

Patient's Name ____________ Patient's Signature ____________ Date ____________

Physician's Signature ____________ Date ____________