Dr. Ann
WELLNESS

Dr. Ann Wellness, LLC
9 Stoll's Alley
Charleston, SC, 29401
tel: 843.329.1238

Please return medical history form at least 5 days prior to scheduled consultation

Name: _____ Cell Phone: (___) _____

Date of Birth: _____ Email: _____

Address: _____

Past Hospitalization/Surgeries: _____

Past Illnesses/Chronic Health Problems: _____

_____

_____

Current Medications: _____

_____

Medication Allergies: _____

Do You Smoke? ☐ Yes ☐ No # per day: _____ # of years: _____

Do You Drink Alcohol? ☐ Yes ☐ No How Much? _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced # of Children: _____

Occupation: _____

Do you exercise regularly? If so, what type of exercise, how much and how often? _____

_____

_____

Do you take any dietary supplements (vitamins/minerals/herbs, etc.). Please list (bring in with you): _____

_____

_____

How do you consider the healthfulness of your diet: ☐ Excellent ☐ Fair ☐ Poor

How do you consider your day to day life: ☐ Extremely Stressful ☐ Moderately Stressful ☐ Minimally Stressful

What aspects of your wellness program are you most interested in focusing on? _____

_____

_____

Family History:

	If Living:		If Deseased:	
	Age	Health	Age	Health
Father				
Mother				
Brother/Sister 1				
Brother/Sister 2				
Brother/Sister 3				
Brother/Sister 4				
Brother/Sister 5				
Brother/Sister 6				
Brother/Sister 7				

Has any blood relative had:

	Circle One		Who
Colon Cancer	yes	no	
Breast Cancer	yes	no	
Uterine Cancer	yes	no	
Ovarian Cancer	yes	no	
Prostate Cancer	yes	no	
Diabetes	yes	no	
Heart Trouble	yes	no	
High BP	yes	no	
Stroke	yes	no	
Depression	yes	no	