LAURA WAGNER, INC.

Patient Information:

Name: _____ DOB: _____
last first m.i.

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred Language:_____

Race: Black White Asian Am.Ind/Alaska Nat Nat Hawaiian/Pacific Islander
Middle Eastern/North African Hispanic/Latino Decline to Specify

Ethnicity: Hispanic/Latino - Yes / No / Decline to specify

Primary Care Physician:_____ Phone:_____

Pharmacy:_____

Phone or Address: _____

Authorized Contact: Name:_____

Relation: _____ Phone:_____

Please complete the next 4 lines if 65 or older.
Do you have an Advanced Care Plan or Surrogate Decision Maker? Y / N
This includes living wills and medical powers of attorney.

Yes: Optional Name and Phone #:_____

No: I do not wish or am unable to name a surrogate or provide an advance care plan.

Have you received Hospice Care since January 1 - Y / N

Patient Name: _____

Reason for Visit:_____

List of **Prescription only** Drugs: ☐ or see attached: _____

_____

List of **Drug** Allergies:_____

Allergy to **Adhesives or Latex**: Y / N Weight:_____

Smoking: Never / Former / Current

Flu Shot This Season:

Y / Date:_____ Not Yet / Declined / Allergic to Shot / Other

Pneumonia Shot on or after your 60th birthday:

Y / Date:_____ Declined / Allergic to Shot / Other

Major Surgical History (Do not include skin cancer, cosmetic or minor surgical procedures):

_____

Family History of Melanoma: Y / N Relationship:_____

Ob/gyn History: Hysterectomy / Tubal Ligation / Pregnant / Nursing / Trying to Conceive

Patient Medical History: Have you been diagnosed or treated for any of the following? Y / N

Circle all that apply

AIDS/HIV	EMPHYSEMA	KIDNEY DISEASE
ARTHRITIS	G.E.R.D.	LIVER DISEASE
ARTIFICIAL HEART VALVE	GLAUCOMA	MIGRAINES
ARTIFICIAL JOINT	HEART DISEASE	ORGAN TRANSPLANT
ASTHMA	HEPATITIS A * B * C	RADIATION THERAPY
CHEMOTHERAPY	HERPES SIMPLEX VIRUS	SEIZURES
COLITIS	HIGH CHOLESTEROL	STROKE
DIABETES	HYPERTENSION	THYROID PROBLEMS
CANCER (type other than skin): _____		TUBERCULOSIS
LIST OTHER CONDITIONS: _____		

Circle all that apply

BASAL CELL CARCINOMA
SQUAMOUS CELL CARCINOMA
MELANONOMA
ACTINIC KERATOSIS

Circle all that apply

DEFIBRILLATOR
PACEMAKER
BLOOD THINNERS

_____ _____

Signature (by: ☐ Patient ☐ Parent/Guardian) Date