VIRTUE MEDICINE P.C.

Clinics in Mind-Body Health

Studio for Ethics & Contemplative Arts

Full Name: _____

Date of birth: _____

Mailing Address: _____

_____

(Home Phone)_____ (Work Phone)_____

(Cell Phone)_____ (Email) _____

I prefer for the medical office to contact me during our business hours at:

❑Home Phone ❑Work Phone ❑Cell Phone ❑Email ❑Specify: _____

Virtue Medicine uses a scheduling program that provides appointment confirmations by email.

❑ ***Check here if you* DO NOT *want appointment confirmations delivered to your email address.***

My Primary Care Physician(s):

_____

_____

Other Care Providers:

_____

_____

If I am unable to make decisions because of severe illness, this is name and contact information for the person I prefer to make emergency decisions for me:

Name _____

Address_____

_____

Phone _____

❑ Partner/Spouse ❑ Friend
❑ Adult Child ❑ Legal Guardian
❑ Parent ❑ _____

Past Medical History and Current Medical Problems (include the date/year of diagnosis)

Previous surgeries or injuries

Family medical history
(indicate the person's relationship to you and the diagnosis)

Caffeine? ☐ None ☐ Estimated 8-ounce caffeinated beverage per day ___

Tobacco? ☐ None ☐ Smoked cigarettes from age ____ to ____. ____ packs per day.
Check if you've used the following: ☐ Cigars ☐ Chewing Tobacco

Alcohol ? ☐ None [ ] Estimated drinks per week ____
Check if you've had the following alcohol complications: [ ] Black-outs [ ] Legal Problems [ ] Withdrawal Symptoms

Drugs? ☐ None [ ] Type(s) and history of use _____

Please list current medications, including supplements or vitamins:

Please list allergies or intolerances of medications, latex, dyes, foods, or other:

Describe your typical physical activities/exercise:

Describe your typical daily diet:

Do you have any concerns about violence or abuse in your current environments? ☐ Yes ☐ No
Have you been a victim of previous violence or abuse? ☐ Yes ☐ No

Signature: _____ Date: _____