



**Courage Center Physicians' Clinic**  
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## Physicians' Clinic Health Information Form

Identification		Emergency Contacts	
Name (Last) (First) (Middle)		In Case of Emergency, Notify: Primary Contact Name (last) (First)	
Date of Birth	Sex: Male Female		
Height	Weight	Relationship	
Race		Phone	
Primary Language			
Person or Family Member Helping Complete Form			
Healthcare Providers			
Healthcare Provider Specialty	Primary Care Physician Yes No	Phone	
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City		State	Zip Code

Physicians' Clinic Health Information Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Healthcare Provider Specialty	Specialty:	Phone	
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City		State	Zip Code

Healthcare Provider Specialty	Specialty	Phone	
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City		State	Zip Code

Healthcare Provider Specialty	Specialty	Phone	
Name		Email Address	
Group or Association		Fax	
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**Social History**

**I live with:**

My Marital Status:    Married    Divorced    Single    Widowed    Significant Other

I have how many children:                      How many live at home?                      How many adult children live in the area?

What type of housing do I live in?:    House    Apt    Trailer    Condo    Group Home    Nursing Facility

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Where is your housing located?:

Accessibility: Are there obstacles in your home that make it difficult to get around?

Occupation: Are you currently working?  
 Not-employed      Full-time      Part-time      On work restrictions      On disability

List Hobbies:

**Equipment Needs**

Please check off any equipment you currently use and list all others:

<input type="checkbox"/>	Power wheelchair	<input type="checkbox"/>	Hand & Wrist splint	<input type="checkbox"/>	Catheter supplies
<input type="checkbox"/>	Manual wheelchair	<input type="checkbox"/>	Shower chair	<input type="checkbox"/>	Wound Supplies
<input type="checkbox"/>	Ankle & Foot Brace (AFO)	<input type="checkbox"/>	Sliding board	<input type="checkbox"/>	Incontinence supplies
<input type="checkbox"/>	Elbow splint	<input type="checkbox"/>	Hoyer Lift	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

**Lifestyle**

How much alcohol do you use per week?	Drink(s) Per Week	Number of Years
Do you smoke? If so, how much?	Pack(s) Per Day	Number of Years
Do you currently exercise?	What type(s) of Exercise?	How many days Per week?
Have you ever used any illicit drugs in the past or present?		

Are you on a special diet: Type:

What is your current weight:

Have there been any recent weight loss or gain ? If so, how many lbs?

**Health Maintenance**

When was your last annual physical? Where?

Have you ever had your bone density tested? If so, where?

For females, when was your last mammogram?

When was your last Tetanus shot?

Have you ever had a Pneumonia Vaccine?

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Have you ever had a Colonoscopy?
When was your last Eye exam?
When was your last Dental exam?
When was your last Cholesterol screening?
<b>Special Considerations</b>
Are there cultural or other considerations we should know in providing for your healthcare?

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<b>Family Member History</b>					
	<b>Mother</b>	<b>Father</b>	<b>Sibling(s)</b>	<b>Grandparent(</b>	<b>Children</b>
Enter ages of relatives					
If deceased, indicate age and cause of death					
<b>Check all items that apply for their present state of health or any illnesses they have had</b>					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
High Blood Cholesterol					
High Blood Pressure					
Kidney Disease					
Seizures					
Stroke					
Thyroid Disorders					
<b>Activities of Daily Living:</b>					
Mobility:    W/C powered <input checked="" type="checkbox"/> W/C manual    Scooter    FWW    SEC					
Transfers:    With assistance of _____    Independent					
Stairs:    Unable    With Assistance					
PCA:    Yes    Hours per day: _____					
Money Management:    Independent    With assistance    Someone else manages					
Speech Language:    Dysarthria <input checked="" type="checkbox"/> Swallowing problems <input checked="" type="checkbox"/> Speech therapy in the past					

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**Review of Systems**

Circle the condition you have now. Put an X by those you have had in the past.

AIDS / HIV

Hepatitis

Anemia

Hypertension

Arthritis

Incontinence of Bladder

Asthma

Incontinence of Bowel

Blood Clots / Transfusion

Kidney disease

Bronchitis / Cough

Low Blood Pressure

Cancer

Nausea / Vomiting

Diabetes

Neurogenic Bladder

Dizziness / Balance problems

Neurogenic Bowel

Double Vision

Pain in Muscles / Joints

Edema / Swelling

Palpatations

Emphysema / Lung Problems

Paraplegia / Quadriplegia

Epilepsy / Seizures

Rheumatic Fever or Rheumatic Disease

Fainting

Skin Ulcers

Fever / Chills

Shortness of Breath

Frequent or Severe Headaches

Stomach, Liver, or Intestinal Problems

Glasses for Distance or Near

Stroke

Hearing Problems / Ringing in the Ears

Tracheotomy Previously

Heart Disease

Thyroid Problems

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**Mental Health History**

Do you see a Psychiatrist:

If so, what is his or her name?

Do you see a Psychologist:

If so, what is his or her name?

Do you have any anxiety?

Do you have any Depression?

Did you or are you having trouble adjusting to your disability?

Have you ever been diagnosed with Bipolar Disorder?

Other:



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