TWMC
The Wellness Medical Clinic
Ammar Alsheikh, MD

New Patient Check-In Form

Patient Name _____ Date of Birth _____	**For Internal Use Only** Height _____ Weight _____ Blood Pressure _____ Pulse _____ Temp _____ Resp _____

Guardian / Support Role (if appropriate)
Name _____ Relationship _____
Role: ___Next of Kin ___ Guardian ___Caregiver

Please provide as much detail as you are able so that we can give you the safest and best care possible.

What is the primary reason for your visit? _____

MEDICATIONS

Please list any medications you are taking, with dose and frequency.

Medication	Dosage	# per Day	Do you need refills?
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____
			Yes____

Please list Vitamins, Supplements and Over the Counter Medicines

_____

_____

Please provide your preferred pharmacy name and location

_____

_____

SOCIAL HISTORY

Marital Status_____ Occupation_____ Employer_____
Exercise? No___ Yes ___ Type_____ Hours per Week _____
How many people other than you reside in your household? ___Spouse ___Children ___Grandparents ___Other
Do you have advance directives? _____
Do you have any religious belief that could affect your medical care?
_____

TOBACCO/ALCOHOL/CAFFEINE/DRUGS

Please check your current tobacco status. ( ) Current ( ) Never ( ) Former

Do you use Alcohol? No__ Yes__ Type_____ Amount_____ Frequency_____

Do you use Caffeine? No__ Yes__ Type_____ Amount_____ Frequency_____

Do you use Illicit Drugs? No__ Yes__ Type_____ Amount_____ Frequency_____

Other

Do you use contraceptives? No___ Yes___ Type_____

Who is your dentist? _____ Telephone _____

Do you have any dental/oral problems? _____

Preventive Care History

Indicate Date of Your Last:

Tetanus Vaccine	_____	Colonoscopy	_____
Flu Vaccine	_____	Stool Check for Blood	_____
Pneumonia Vaccine	_____	PSA (♂)	_____
Shingles Vaccine	_____	Mammogram (♀)	_____
EKG/Heart Stress Test	_____	Pap Smear (♀)	_____
Chest Xray	_____	Bone Density/DEXA	_____
Visit with Eye Doctor	_____	Visit with Dentist	_____

In the past 2 weeks, have you had little interest or pleasure in doing things?
Not at all (0)___ Several days (1)___ More than half the days(2)___ Nearly every day (3)___
In the past 2 weeks, have you been feeling down, depressed or hopeless?
Not at all (0)___ Several days (1)___ More than half the days(2)___ Nearly every day (3)___

Please list your most recent Health Care Provider(s) _____

How did you hear about us? _____

ALLERGIES

Please list any allergies and intolerances to **medications**

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

Do you have an Egg, Neomycin or Gelatin allergy? No___ Yes____

Do you have an allergy to intravenous contrast? No___ Yes____

Please list any allergies to **food** or the **environment**

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

__Allergies	__Blood Clots	__Gallbladder Disease	__Heart Attack
__Anemia	__Cancer (type)_____	__GERD – Reflux	__Osteoarthritis
__Angina	__Stroke	__Hepatitis C	__Ulcers
__Anxiety	__COPD	__High Cholesterol	__Kidney Disease
__Arthritis	__Heart Disease	__Hypertension	__Seizure Disorder
__Asthma	__Crohn's Disease	__Irritable Bowel	__Thyroid Disease
__Atrial Fibrillation	__Depression	__Liver Disease	
__Prostate Enlargement	__Diabetes	__Migraines	

Other medical problems:

_____

_____

SURGICAL HISTORY

What **surgeries** have you had? Please mark **all** that apply and include the year they were performed.

__Angioplasty_____ __Gastric Bypass_____
__Angio w/Stent_____ __Hernia Repair_____
__Appendectomy_____ __Knee Replacement_____
__Arthroscopic Knee_____ __LASIK_____
__Back Surgery_____ __Liver Biopsy_____
__Heart Bypass_____ __Pacemaker_____
__Carpal Tunnel_____ __Bowel Resection_____
__Cataract Extraction_____ __Thyroidectomy_____
__Gallbladder Removal_____ __Tonsillectomy_____

Men Only:

__Prostate Biopsy_____ __Transurethral Resection_____ __Vasectomy_____

Women Only:

__Augmentation Mammoplasty_____ __Mastectomy_____
__Bilateral Tubal Ligation_____ __Myomectomy_____
__Breast Biopsy_____ __ Reduction Mammoplasty _____
__Cesarean Section_____ __TAH/BSO_____
__Dilation and Curettage _____ __Vaginal Hysterectomy_____
__Hysterectomy_____

Other surgeries:

_____

Have you had any recent hospitalizations or ER visits?

_____

_____

FAMILY HISTORY

Mother ___Alive ___Deceased (age at death)_____ Cause of Death _____
Medical problems _____
Father ___Alive ___Deceased (age at death)_____ Cause of Death _____
Medical problems _____
Siblings Number of Brothers____ Number of Sisters ____ Medical problems _____
Children Number of Sons ____ Number of Daughters ____ Medical problems _____
Have any of the women in your family had a heart attack/heart disease at age 65 or younger? No___ Yes ___
Have any of the men in your family had a heart attack/heart disease at age 55 or younger? No___ Yes ___

Any additional pertinent family history:

_____

HEALTH CARE POWER OF ATTORNEY

Statutory Long Form

1. **Health Care Power of Attorney**

I, _____, as principal, designate _____, as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint _____ as my agent.

I have _____ I have not _____ completed and attached a living will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

I have _____ I have not _____ completed a prehospital medical care directive pursuant to Section 36-3251, Arizona Revised Statutes.

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

2. **Autopsy** (Under Arizona law an autopsy may be required.)

If you wish to do so, reflect your desires below:

_____ 1. I **do not** consent to an autopsy.

_____ 2. I **consent** to an autopsy.

_____ 3. My agent **may** give consent to **or refuse** an autopsy.

3. **Organ Donation** (Optional)

(Under Arizona law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law.) The donation elections you make in this health care Power of Attorney survive your death.

If any of the statements below reflects your desire, initial on the line next to that statement. **You do not have to initial any of the statements.**

If you do not check any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Arizona law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution: _____

_____ Pursuant to Arizona law, I hereby give, effective on my death:

[ ] Any needed organ or parts.

[ ] The following part or organs listed:

_____ _____ _____

For (check one):

[ ] Any legally authorized purpose.

[ ] Transplant or therapeutic purposes only.

4. **Physician Affidavit** (Optional)

(Before initialing any choices above you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his file.)

I, Dr. _____ have reviewed this guidance document and have discussed with _____ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on (Date) _____ .

I have agreed to comply with the provisions of this directive.

Signature of Physician _____

Verification

I affirm that: (1) I was present when this health care power of attorney was dated and signed or marked or (2) the person making this power of attorney directly indicated to me that the power of attorney expressed that person's wishes and that the person intended to adopt this power of attorney at that time.

I certify that: I have not been designated to make medical decisions for the person who signs this health care power of attorney, I am not directly involved with providing health care to that person, I am not related to that person by blood, marriage, or adoption and I am not entitled to any part of that person's estate.

Signature or Mark of Principal _____

Date: _____ Time: _____

Address of Agent _____ Telephone of Agent _____

Witness: _____ Address: _____

Witness: _____ Address: _____

(NOTE: This document may be notarized instead of being witnessed.)

LIVING WILL

Statutory Short Form

This living will is effective only while I am unable to make or communicate my health care decisions.

(Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should ***initial*** *that statement.* ***Read all of these statements carefully before you initial your selection.*** *You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3, and 4, but if you initial paragraph 5 the others should* ***not*** *be initialed.)*

1. _____ If I have a terminal condition I **do not** want my life to be prolonged and I **do not** want life-sustaining treatment, beyond comfort care, that would serve **only** to artificially delay the moment of my death.

2. _____ If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I **do** want the medical treatment necessary to provide care that would keep me comfortable, but I **do not** want the following:

   (a)_____ Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.

   (b)_____ Artificially administered food and fluids.

   (c)_____ To be taken to a hospital if at all avoidable.

3. _____ Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

4. _____ Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

5. _____ I want my life to be prolonged to the greatest extent possible.

Other or Additional Statements of Desires

I have _____ I have not _____ attached additional directions or limitations to this Living Will to be honored in the absence of my being able to give health care directives.

Signature or Mark of Person making Living Will _____

Date: _____

Verification

I affirm that: (1) I was present when this living will was dated and signed or marked or (2) that the person making this living will directly indicated to me that the living will expressed that person's wishes and that the person intended to adopt it at that time. I affirm further that the person making this health care living will appeared to be of sound mind and free from duress at the time of its execution.

I certify that I have not been designated to make medical decisions for the person who signed this living will and am not directly involved with providing health care to that person. If this Living Will is witnessed only by me, I certify that I am not related to the person making this Living Will by blood, marriage, or adoption and am not entitled to any part of that person's estate.

Witness: _____ Address: _____

Witness: _____ Address: _____

Date: _____ Date: _____