PIPE TRADES SERVICES MN
FAMILY HEALTH & WELLNESS CENTERS
Serving the pipe trades industry in Minnesota

Today's Date:_____

Name:_____ **DOB**:_____

Occupation:_____ **Single/ Married/ Divorced/ Separated/ Significant other**

Children (names and ages):

Number of people in household and relationship:

Reason for your visit today:

Medical History

Health Concern	Check if yes	Health Concern	Check if yes
Alcoholism		Hypertension (high blood pressure)	
Allergies		Mental Health Disorders	
Alzheimer's disease		Migraine headache	
Arthritis		Neurological disorders	
Asthma		Obesity	
Cancer (indicate type)		Osteoporosis	
Diabetes		Stroke	
Heart Disease/heart attack			

Surgical History

Please list all surgeries you have had and the dates.

Family Medical History

Please indicate which blood relatives (mother, father, grandparents and siblings)

Health Concern	Family Member	Health Concern	Family Member
Alcoholism		Mental Health Disorders	
Allergies		Migraine headache	
Alzheimer's disease		Neurological disorders	
Arthritis		Obesity	
Asthma		Osteoporosis	
Cancer (indicate type)		Stroke	
Diabetes			
Heart Disease		Early death from any cause	
Hypertension			

Medications/ Supplements/ Vitamins

Please check any of the following medications that you are taking or have taking or have taken in the last 2 years:

- € Blood Pressure
- € Diabetes
- € Diuretics (water pills)
- € Sleeping Pills
- € Recreational Drugs
- € Aspirin/ Tylenol
- € Laxatives
- € Birth Control Pills
- € Pain Relievers
- € Allergies

Any known allergies or drug sensitivities?_____

Medications (if more space is needed, please attach a separate sheet)

Listing of Drugs	Dosage/ Amount	Reason for Taking	Duration of Use

Do you Smoke or Chew? Yes/ No If so how much? _____

Do you drink alcohol? Yes/ No

In one week how many glasses do you consume and how often?_____

How often do you exercise?_____

What type of exercises do you do? (e.g. strength training, stretching, cardio):_____

_____

Thank you for your response!
Your Wellness Team