WeCare Cosmetic & Surgical
Women's Center
520 Bustleton Pike, Ground floor
Feasterville, PA 19053
Tel: (215) 631-3873

NAME ______________________ AGE ________

ADDRESS ______________________

HOME PHONE ________ EMAIL ADDRESS ________
WORK PHONE ________ DATE OF BIRTH ________
CELL PHONE ________

PREFERED PHONE TO CONTACT YOU ____________________ MARITAL STATUS ______________

LANGUAGE PREFERECE ________
SOCIAL SECURITY NUMBER ________ RACE ________

EMERGENCY CONTANT NAME AND PHONE ________

PRIMARY CARE PHISICIAN: ________
PHONE: ________
FAX: ________

MAY WE SHARE YOUR RECORDS WITH PRIMARY CARE PHYSICIAN? YES / NO

MAY WE LEAVE A MESSAGE ON YOUR MACHINE? YES / NO

YOUR PHARMACY NAME: ________
ADDRESS: ________
PHONE: ________

PLEASE, LIST YOUR PAST / CURRENT MEDICAL PROBLEMS

PREVIOUS HOSPITALIZATIONS AND SURGERIES

ALLERGIES

PLEASE, LIST YOUR CURRENT MEDICATIONS WITH DOSES AND FREQUENCY

PLEASE, LIST ANY MEDICAL PROBLEMS IN FAMILY MEMBERS WITH AGE OF ONSET (HYPERTENSION, DIABETES MELLITUS, CANCER)

MOTHER:
FATHER:
BROTHER/SISTER:
OTHERS:

SMOKING HISTORY?
DO YOU DRINK ALCOHOL? IF YES, HOW OFTEN?
DO YOU EXERCISE? HOW FREQUENT?
HISTORY OF ANY DRUGS USE? MARIJUANA?
YOUR OCCUPATION?
WHO DO YOU LIVE WITH?

FEMALE PATIENTS:

LAST MENSTRUAL PERIOD?
HOW MANY PREGNANCIES DID YOU HAVE?
HOW MANY MISCARRIAGES / ABORTIS DID YOU HAVE?
HOW MANY CHILDREB DO YOU HAVE?
IF MENOPAUSE, HOW MANY YEARS?

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INSURANCE HOLDER INFORMATION NAME

RELATIONSHIP TO PATIENT SOCIAL SECURITY

ADDRESS

| | | | POLICY# | GROUP# |
|---|---|---|---|---|
| PHONE | | PRIMARY INSURANCE | | |
| | | SECONDARY INSURANCE | | |

e-mail: mail@wecaremedicalgroup.org www.wecaremedicalgroup.org