8530 Eagle Point Blvd. Suite 100 Lake Elmo, MN 55042
Phone: 651-333-9133 | Fax: 1-651-560-7013 | frontdesk@timewisemedical.com |

Patient Information:

Name: _____ Date of Birth: _____ Sex: M □ F □
(First name) (Middle Initial) (Last Name)

Address: _____ City:_____ State: _____ Zip: _____

Phone: _____ Can we leave a detailed message? : Yes □ No □

Email Address : _____

Emergency Contact Information:

Emergency Name: _____ Relationship: _____
(First name) (Middle Initial) (Last Name)

Emergency Address: _____ City:_____ State: _____ Zip: _____

Emergency Phone Number: _____

Please list your qualifying Medical Condition: _____

Severity of symptoms:

1 2 3 4 5 6 7 8 9 10

Frequency of symptoms (rare, intermittent, frequent, constant):

Please describe your symptoms:_____

_____

_____

Please circle YES or NO:

Pregnant? YES NO

Diagnosed with schizophrenia or schizoaffective disorder? YES NO

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Are you allergic to any medication? Yes □ No □ (If yes, please list below)_____

_____

Current Medication(s): _____

_____

Past Medical History: (Please check all that applies)

Diabetes □	Chest Pain/Angina □	High Blood Pressure □	Heart Disease □	Pacemaker □
Headache □	Kidney Stones □	High Cholesterol □	Kidney Disease □	Cancer □
Arthritis □	Osteoporosis □	Heart Palpitations □	Stroke/CVA/TIA □	Seizure □
HIV/AIDS □	Stomach Ulcer □	Liver Disease □	Hepatitis □	Asthma/COPD □
Depression □	Heart Surgery □	Congestive Heart Failure □	Peripheral Vascular Disease □	
Blood Clots □	Tuberculosis □	Thyroid Disease □		

Other: _____

Family History: (Please list any known medical problems)

Father: _____ Mother:_____

Siblings: _____

Your Children: _____

Grandparents: _____

Social History:

Marital Status: _____ Occupation: _____

Smoke: Never □ Ex-Smoker □ Current Smoker □ How many packs per day? _____

Alcohol: Never □ Occasional: □ Frequent □

Additional Information:_____

Doctor's Signature: _____ Signature of Patient: _____