

# Welcome To Health Concepts I

560 N Jeff Davis Drive  
Fayetteville, Georgia 30214  
770-719-8785

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Please list any health history pertaining to female, hormone or breast health:  
This information is confidential.

## Current Medical History

Medication: \_\_\_\_\_

Condition: \_\_\_\_\_

Illnesses: \_\_\_\_\_

## Past Medical History

Surgery: \_\_\_\_\_

Fractured / Broken Bones: \_\_\_\_\_

Illnesses: \_\_\_\_\_

## Family History

Known Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

## Current Breast Complaints

Lump: \_\_\_\_\_

Rash: \_\_\_\_\_

Soreness: \_\_\_\_\_

Other: \_\_\_\_\_

Area Of Interest: \_\_\_\_\_

Current Problem/Concern in Area: \_\_\_\_\_

\_\_\_\_\_

## Other Areas of Complaint: (Please list concerns by area identified)

Arms \_\_\_\_\_ Hands \_\_\_\_\_

Legs \_\_\_\_\_ Feet \_\_\_\_\_

Abdomen \_\_\_\_\_ Neck \_\_\_\_\_

Face \_\_\_\_\_ Feet \_\_\_\_\_

Shoulder \_\_\_\_\_ Knee \_\_\_\_\_

I verify this information is correct and I understand I am responsible for my bill.

Signed \_\_\_\_\_ Date \_\_\_\_\_