

Wellness Exam Instructions

The Wellness Examination focuses on your medical history, your family history, as well as doing an examination and lab work. We combine this information to obtain an overall view of your health and focus on areas of risk. Please fill out the first three pages of this form.

Imprint area

Wellness Exam - Adult

Name _____ Male Female Date of Birth _____

Home Address _____

Home Phone _____ Cell _____ Work Phone _____

Occupation _____ Spouse's name and Occupation _____

Social Security # _____ Employer _____

Please answer all questions on the following three pages.
Write "unknown" or "NA" instead of leaving blanks.

Date _____

Part 1 — Personal Health

	<u>YES</u>	<u>NO</u>
Have you had any of the following?		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Unusually severe depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Positive TB (tuberculosis) skin test	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment to any part of body	<input type="checkbox"/>	<input type="checkbox"/>
DES exposure (mother received hormones When pregnant with you)	<input type="checkbox"/>	<input type="checkbox"/>
Other chronic Medical Problems _____		

Immunizations:

Date of last tetanus _____

If over 65, ever had pneumonia vaccine _____

Date Hepatitis B series completed _____

Date Hepatitis A series completed _____

Last **sigmoidoscopy**/colonoscopy _____

Women only:

Date of last Pap smear _____

Have Pap smears been normal _____

Date of last Mammogram _____

Have your mammograms been normal _____

Date of last bone density _____

Medications that you take regularly:

Name	Dosage	Why do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication allergies:

Name	Reaction	Year

Major Operations and Hospitalizations: None

Year	Specify Illness or Type of Surgery	Name of Hospital
A		
B		
C		
D		

Part II—Family Health

Has any family member had:

Who? (Specify relationship and if deceased, age at death)

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Colon or Rectal Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Alcoholism/Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Suicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	

Name any additional health related conditions that run in your family: _____

Part III—Social & Lifestyle

Marital Status:

Married Divorced Single Widow Widower Separated

Who lives at home with you? (Such as spouse, sons, daughters, father-in-law, etc.): _____

Current method of birth control: _____ N/A

Have you had more than 1 sexual partner in the past 12 months? Yes No

Are you concerned about your AIDS risk? If yes, explain: _____ Yes No

Sources of Tension and Worry:

Job Marriage Alcohol/Addic. Children Finances Co-workers
 Drugs Religion Relatives Other: _____

Check the Answer Most Appropriate for the Following Areas:

Tobacco

- Have never smoked.
- Smoke cigarettes. (Number of packs/day _____ Number of years _____)
- Smoke cigar or pipe. How much? _____
- Quit smoking. When? _____ What did you smoke? _____
How much did you smoke? (Number of packs/day _____ Number of years _____)
Do you use smokeless tobacco? Yes No

Alcohol (One drink equals 1 shot of liquor, 1 glass of wine or 1 can of beer):

Four or more drinks/day 1-3 drinks/day Less than 5 drinks/week None
Number of alcohol free days per week: _____

Caffeine

Coffee Tea Cola Total number of cups/glasses/bottles per day: _____

Exercise

What do you do for exercise? _____
#days/week _____ #minutes/day _____

Nutrition

servings/day fruits or vegetables? _____ # servings/day whole grains _____
Do you eat breakfast regularly? _____ #meals eaten out/week _____
Describe any special diet _____

Review of Systems

Please list and explain any current problems.

- | | Good <input type="checkbox"/> | Fair <input type="checkbox"/> | Poor <input type="checkbox"/> |
|--|-------------------------------|-------------------------------|-------------------------------|
| 1. How would you describe your health?
Why? _____ | | | |
| | | <u>Yes</u> | <u>No</u> |
| 2. In the past 6 months, have you lost more than 10lbs. without trying?
Comment _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you noticed any major changes in your skin (moles, etc.) recently?
Describe _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have poor hearing or other ear problems?
Describe _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a persistent cough or hoarse voice?
Describe _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have shortness of breath?
Describe _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you get chest pain when you are active?
Describe _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been told you have a heart murmur?
Explain _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you frequently have heartburn or stomach pain?
What do you do for it? _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have blood in your bowel movements or a change in character of
your bowel movements? Describe _____
_____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have significant joint or bone problems, or back/neck pain that interferes
with your work or lifestyle? Explain _____
_____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have any breast lumps? Describe _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have abnormal vaginal bleeding (including bleeding after menopause?)
_____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are there sexual problems you wish to discuss? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any other questions or problems you wish to discuss?
Explain _____ | | <input type="checkbox"/> | <input type="checkbox"/> |