**Wellone Primary Medical and Dental Care - Adult Health History**

**Name _____ Date of Birth: _____ Phone: _____**

**Pharmacy Name: _____Pharmacy Address:_____**

**Who was your previous medical provider: _____**

**Do you have an advance directive or living will? Advanced Directive: ☐Yes ☐No Living Will: ☐ Yes ☐No**

**Immunizations with dates** (if unknown, write unknown)

| Vaccine | Date (s) | Vaccine | Date (s) |
|---|---|---|---|
| Pneumonia shot | | Hepatitis B Series | |
| Flu shot | | MMR | |
| Whooping Cough(Pertussis)/Tdap | | Chicken Pox Vaccine | |
| Tetanus Shot | | Meningitis | |
| Zoster/Shingles | | HPV Shot | |

**Tobacco Use:** ☐ Past/I Quit ☐ Never ☐ Current How much per day? _____How Long:_____
Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Other? _____

**Specialists (include dentist, eye doctor, gynecologist, counselor/therapist etc)? ☐ No Specialists**

| Specialty | Name | Date Last Visit | Reason For Visit |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Have you had an allergic reaction to medications, foods, latex or any other substances? ☐ No Allergies**

| Allergy | Reaction/What Happens | Allergy | Reaction/What Happens |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Medication History: Please list all medications (Prescription/over the counter/herbal/vitamins) you are taking:**
**☐ I do not take any medications**

| Medication Name | Dose /Times per day | Reason For Taking | Who Prescribes? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Health History:**

| Disease/Condition | Date / Explain | Disease/Condition | Date / Explain |
|---|---|---|---|
| Seizures | | Reflux/GERD | |
| Head Trauma | | Colon Cancer | |
| Cerebral Aneurysm | | Hemorrhoids | |
| Stroke/TIA | | Colon Polyps | |
| Alzheimer's | | Diverticulitis/diverticulosis | |
| Migraine | | Crohn's Disease | |
| Trouble Seeing | | Colitis | |
| Glaucoma | | Irritable bowel | |
| Cataracts | | Liver Disease | |
| Hard of Hearing/Deafness | | Hepatitis | |
| Blood Transfusion | | Kidney Disease | |
| Anemia | | Bladder Cancer | |
| Blood clots in legs/lungs | | Frequent UTI (urinary tract infections) | |
| History of Heart Attack | | Psoriasis/Eczema | |
| Angina/chest pain | | Skin Cancer | |
| High Blood Pressure | | Breast Cancer | |
| High Cholesterol | | Abnormal Mammogram | |
| Heart Failure (CHF) | | Diabetes | |
| Atrial Fibrillation | | PreDiabetes | |
| Murmur | | Thyroid problem | |
| Asthma | | Gout | |
| Emphysema/COPD | | Rheumatoid Arthritis | |
| Sleep Apnea | | Arthritis | |
| Lung Cancer | | Osteoporosis/Osteopenia | |
| Tuberculosis | | Pain | |
| Positive PPD | | Anxiety | |
| HIV | | Bipolar | |
| Shingles | | Depression | |
| Rheumatic Fever | | Suicide Attempt | |
| Lyme Disease | | Schizophrenia | |
| Chlamydia | | Eating Disorder | |
| Gonorrhea | | PTSD | |
| Herpes | | ADD/ADHD | |
| Genital Warts/HPV | | Drug Addiction | |
| Chicken Pox Disease | | Alcoholism | |

**OTHER:** _____

_____

**Females:** ☐ Abnormal Pap smear ☐ LEEP ☐ Colposcopy ☐ Cone Biopsy ☐ Cervical Cancer ☐ Uterine Cancer
Describe above: _____
Date of last PAP: _____Who did the PAP _____Date of Menopause_____
☐ Gestational Diabetes (diabetes during pregnancy) ☐ DES Exposure # Pregnancies_____ # Deliveries_____
# Miscarriage_____ # Abortion_____ ☐ Ectopic (tubal) pregnancy Comments: _____
**Males:** ☐ Testicular Cancer ☐ Prostate Cancer ☐ Prostatitis ☐ Enlarged prostate (BPH) ☐Undescended testicle
☐ Erectile Dysfunction Comments: _____

**Patient Name: _____** **Patient Date of Birth _____**

**Surgeries: (Please be as specific as possible- example: left hip replacement)** ☐ **No known surgeries**

| Surgery | Date of Surgery/ Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Family medical history: Please be specific for cancers (kind, location if known)** ☐ **I do not know my family history**

| | Conditions/Diseases |
|---|---|
| Mother | |
| Father | |
| Sister (s) | |
| Brothers (s) | |
| Children | |
| Grandparents | |
| Other: | |

**Sexual Health:** Sexual Preference: ☐ Male ☐ Female ☐ Both

Are you sexually active? ☐ Yes, Currently ☐No, have been in past ☐ No, Never

# Current Partners_____ # Lifetime Partners____ Has any partner used IV drugs? ☐ No ☐ Yes ☐ Unsure

What are you using to prevent pregnancy?_____Do you use condoms : ☐ Sometimes ☐ Always ☐ Never

**Social and Health Habits:**

| |
|---|
| How often do you drink alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never ☐ Rarely<br>What do you drink? _____ |
| Is your alcohol use a concern for you or others? ☐ No ☐ Yes Explain: _____ |
| Do you use cocaine or other recreational drugs? ☐ Currently ☐ Never ☐ Past/Former<br>What drugs? _____ |
| Do you now or have you ever had a problem with prescription drug use? ☐ Currently ☐ Never ☐Past/Former<br>What drugs? _____ |
| Do you feel emotionally, financially, sexually, verbally or physically abused?☐ Current ☐ Never ☐ In the Past<br>Comments: _____ |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed |
| Who do you live with? _____ |
| Employment Status: ☐ Seeking employment ☐ Unemployed ☐ Disabled ☐ On LOA ☐ Work Full-time ☐ Work Part-Time ☐ Work Per-diem Occupation:_____ |

**Patient Signature**: _____**Print Name:** _____**Date** _____

**Provider Signature:**_____**Date**_____