WellOne Primary Medical and Dental Care - Adult Health History

Name _____ Date of Birth: _____

Gender Assigned at birth: ☐ Female ☐Male

What is your current gender identity? ☐Woman ☐Man ☐Transgender (female to male) ☐Transgender (male to female) ☐Non-Binary/Gender Queer ☐_____

Pharmacy Name: _____Pharmacy Address:_____

Who was your previous medical provider: _____
Do you have an advance directive or living will? Living Will: ☐ Yes ☐No DPA: ☐ Yes ☐No Health Care Proxy: ☐ Yes ☐No

Date of last eye exam?	
Date of last colonoscopy?	
Date of last Bone Density/DEXA	
Have you been to the ER or hospital in the past six months? Why?	

Tobacco Use: ☐ Past/I Quit (Quit Date: _____) ☐ Never ☐ Current
How much per day? _____ How many years did or have you used tobacco: _____
Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Vaporizer ☐ Electronic Cigarette_____
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:

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

Health History: Have you been diagnosed or taking medications for any of the following conditions?

In general, would you say your health is ☐ Excellent ☐Very good ☐Good ☐Fair ☐Poor

Condition	✓	Date	Condition	✓	Date	Condition	✓	Date
Seizures			Asthma			Liver Problem		
Head Trauma			Emphysema			Hepatitis		
Cerebral Aneurysm			COPD			Kidney Problem		
Stroke or TIA			Sleep Apnea			Frequent UTI		
Alzheimer's or Dementia			Tuberculosis			Diabetes		
Migraine			Positive PPD			Thyroid Problem		
Glaucoma			HIV			Autoimmune disease		
Cataracts			Shingles			Gout		
Deafness			Chlamydia			Rheumatoid Arthritis		
Anemia			Gonorrhea			Arthritis		
DVT			Genital Herpes			Osteoporosis		
History of Heart Attack			Genital Warts, HPV			Pain		
Angina			Chicken Pox			Anxiety		
High Blood Pressure			GERD			Bipolar		
High Cholesterol			Hemorrhoids			Depression		
Heart Failure (CHF)			Colon Polyps			Suicide attempt		
Atrial Fibrillation (AFIB)			Diverticulitis, Diverticulosis			Schizophrenia		
Murmur			Crohn's Disease			Eating Disorder		
Valve Prolapse			Colitis			PTSD		
Arteriosclerosis			Irritable Bowel			ADD or ADHD		
Psoriasis or Eczema			Abnormal Mammogram			Drug addiction		
						Alcohol Use Disorder		

Cancer: type(s)_____ Date: _____

I received ☐Chemotherapy ☐Radiation ☐Surgery _____

List any condition not listed here?

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: _____

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

Surgery	Date of Surgery/ Reason

Patient Name: _____ Patient Date of Birth _____ page 3

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

	Conditions/Diseases	
Mother		☐ Deceased
Father		☐ Deceased
Sister (s)		☐ Deceased
Brothers (s)		☐ Deceased
Children		☐ Deceased
Grandparents		☐Deceased
Other:		☐Deceased

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

Would you like to become pregnant in the next year? ☐Yes ☐No 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 Have you ever felt you should cut down on your drinking? ☐ No ☐ Yes Have people annoyed you by criticizing your drinking? ☐ No ☐ Yes Have you ever felt bad or guilty about your drinking? ☐ No ☐ Yes Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐ No ☐ Yes
Do you now or have you ever had a problem with prescription drug use? ☐ Currently ☐ Never ☐Past/Former What drugs? _____
Do you use street drugs such as cocaine or marijuana? ☐ Currently ☐ Never ☐ Past/Former What drugs? _____
Do you feel emotionally, financially, sexually, verbally or physically abused?☐ Current ☐ Never ☐ In the Past Comments: _____
How often do you talk to people that you care about? ☐less than once per week ☐1 or 2 times per week ☐3 to 5 times per week ☐ More than 5 times per week
Employment Status: ☐ Unemployed & Seeking employment ☐ Unemployed ☐ Disabled ☐ On LOA ☐ Work Full-time ☐ Work Part-Time ☐ Work Per-diem
Education: What is the highest level that you have finished? ☐No formal education ☐Less than elementary ☐ Elementary School ☐Middle School ☐High School/GED ☐Trade School ☐2 year college ☐ 4 year college ☐ Graduate/professional ☐Other Certificate
Needs: In the past year have you or anyone you live with been unable to get any of the following when you really needed it? ☐ Food ☐ clothing ☐Utilities ☐Rent/Mortgage payment ☐Transportation ☐Child Care ☐Phone ☐ Medicine or medical Care ☐Health insurance ☐ Other _____
Housing: What is your housing situation today? ☐ I have housing ☐ I do not have housing (staying with others, in a hotel, on the street or a shelter) Who do you live with? _____

Patient Signature: _____**Date** _____

Provider Signature: _____**Date**_____