wellOne Primary N	<u>riedicai</u>	and Dental Care - Ad	duit Healt	n Histor	<u>y - Initial</u>			
Name					Da	te of Birth:		
Gender Assigned a	t birth:	☐ Female ☐ Mai	le					
-	_	er identity? □ Woma ı/Gender Queer □			_	nale to male) 🛘 Transgender (male		
Emergency Contact	mergency Contact:					Relationship:		
Pharmacy Name: _		Pharmacy A	Address:_					
Who was your prev Do you have an adv	ious m ance dir	edical provider: rective or living will? Liv	ing Will: [	☐ Yes ☐	No DPA: □ Ye	es □ No Health Care Proxy: □ Yes □ N		
Date of last eye ex	am?							
Date of last colone		)						
Date of last Bone		' '						
Have you been to t	he ER o	r hospital in the past six	months? \	Why?				
How much per day Type: ☐ Cigarettes <b>Specialists (include</b>	?Cig	ars □ Pipe □ Chew t, eye doctor, gynecolo	low many ing Tobac gist, coun	years d co 🗆 \ selor/th	id or have you /aporizer □ El erapist etc.)?	used tobacco: ectronic Cigarette No Specialists		
Specialty	Name	9	Date Las	t Visit	Reason For V	'isit		
Have you had an al	lergic ro	eaction to medications	. foods, la	tex or a	ny other subst	ances? □ No Allergies		
						Reaction/What Happens		
		тошения и подраждения			<u> </u>	устана порти		
			rescriptio			erbal/vitamins) you are taking:		
Medication Name		Dose /Times per day		Reason	n For Taking	Who Prescribes?		

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,			Schizophrenia		
			Diverticulosis					
Murmur			Crohn's Disease			Eating Disorder		
Valve Prolapse			Colitis			PTSD		
Arteriosclerosis			Irritable Bowel			ADD or ADHD		
Psoriasis or Eczema			Abnormal			Drug addiction		
			Mammogram					
						Alcohol Use Disorder		
Cancer: type(s)			<u>-</u>			Date:		
I received □Chemotherap	у □ Г	Radiation	ı □Surgery					
List any condition not liste	ed her	e						
escribe above:						☐ Cervical Cancer ☐ Uterin		
ate of last PAP: Date of Menopause Date of Menopause Bestational Diabetes (diabetes during pregnancy)    DES Exposure # Pregnancies # Deliveries								
Miscarriage # Abor	นบท	⊔	Ectopic (tubai) pregi	iancy	comm	ents:		
<u><b>Males:</b></u> □ Testicular Cancer	☐ Pro	state Ca	ncer □ Prostatitis □	l Enla	rged pro	ostate (BPH) 🗆 Undescende	ed testic	:le 🗆
ysfunction Comments:								
	- ::::-	ac nacci	hle- example: left hi	p rep	laceme	nt) 🔲 No known surge	eries	
urgeries: (Please be as sp	есніс	as possi	_			-,		
urgeries: (Please be as sp Surgery	естіс	as possi	Date of Surge			,		

Patient Name:							
Family medical his	story: 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						
<u>Sexual Health:</u>							
	$\square$ Male $\square$ Female $\square$ Both. Are you sexually active? $\square$ Yes, currently $\square$ No, have been in past						
☐ No, Never # Cı	urrent Partners # Lifetime Partners has any partner used IV drugs? ☐ No ☐ Yes ☐ Unsure						
Would you like to b	ecome 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 yo	u drink alcohol or use drugs? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never ☐ Rarely						
Have you ever fe	It you should cut down on your drinking or drug use? ☐ No ☐ Yes						
· ·	oyed you by criticizing your drinking or drug use?						
Have you ever felt bad or guilty about your drinking or drug use? ☐ No ☐ Yes							
1	ad a drink or used drugs first thing in the morning to steady						
-	get rid of a hangover (eye-opener)?						
	ave you ever had a problem with prescription drug use?   Currently   Never   Past/Former						
-	ave you ever had a problem with prescription drug user in currently in Never in Past/Former						
What drugs?	t drugs? Currently D Nover D Doct/Former						
	t drugs?  Currently  Never Past/Former						
What drugs?							
1	ionally, financially, sexually, verbally or physically abused?   Current   Never   In the Past						
	u talk to people that you care about? $\square$ Less than once per week $\square$ 1 or 2 times per week $\square$ 3 to 5						
times per week	☐ More than 5 times per week. Are you satisfied with this amount of contact? ☐ Yes ☐ No						
Employment Sta	tus: ☐ Unemployed & Seeking employment ☐ Unemployed ☐ Disabled ☐ On LOA ☐ Work Full-						
time 🗆 Work Pa	art-Time 🛘 Work Per-diem 🗀 Student 🗀 Retired Occupation:						
	is the highest level that you have finished? ☐ No formal education ☐ Less than elementary						
☐ Elementary Sc	hool ☐ Middle School ☐ High School/GED ☐ Trade School ☐ 2 year college ☐ 4 year college						
☐ Graduate/pro	fessional  Other Certificate						
	ve any problems getting any of the following: Food □ No □ Yes Utilities □ No □ Yes						
-	No □ Yes Medicine/Medical Care □ No □ Yes Health insurance □ No □ Yes						
•	payment□ No □ Yes □ Other						
Housing: What is	your housing situation today?   I have housing   I do not have housing						
Who do you live	with?						
Do you have any	with?						
บบ you nave any	concerns for you or your family's safety □ No □ Yes						
Dation Circ							
ratient Signature	Date						

Date

Provider Signature: