

WellOne Primary Medical and Dental Care - Adult Health History - Initial

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 _____

Emergency Contact: _____ Phone: _____ Relationship: _____

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?

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	<input type="checkbox"/> Deceased
Father	<input type="checkbox"/> Deceased
Sister (s)	<input type="checkbox"/> Deceased
Brothers (s)	<input type="checkbox"/> Deceased
Children	<input type="checkbox"/> Deceased
Grandparents	<input type="checkbox"/> Deceased
Other:	<input type="checkbox"/> Deceased

Sexual Health:

Sexual Orientation: 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 or use drugs? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Never <input type="checkbox"/> Rarely
Have you ever felt you should cut down on your drinking or drug use? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have people annoyed you by criticizing your drinking or drug use? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever felt bad or guilty about your drinking or drug use? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you now or have you ever had a problem with prescription drug use? <input type="checkbox"/> Currently <input type="checkbox"/> Never <input type="checkbox"/> Past/Former What drugs? _____
Do you use street drugs? <input type="checkbox"/> Currently <input type="checkbox"/> Never <input type="checkbox"/> Past/Former What drugs? _____
Do you feel emotionally, financially, sexually, verbally or physically abused? <input type="checkbox"/> Current <input type="checkbox"/> Never <input type="checkbox"/> In the Past Comments: _____
How often do you talk to people that you care about? <input type="checkbox"/> Less than once per week <input type="checkbox"/> 1 or 2 times per week <input type="checkbox"/> 3 to 5 times per week <input type="checkbox"/> More than 5 times per week. Are you satisfied with this amount of contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Status: <input type="checkbox"/> Unemployed & Seeking employment <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> On LOA <input type="checkbox"/> Work Full-time <input type="checkbox"/> Work Part-Time <input type="checkbox"/> Work Per-diem <input type="checkbox"/> Student <input type="checkbox"/> Retired Occupation: _____
Education: What is the highest level that you have finished? <input type="checkbox"/> No formal education <input type="checkbox"/> Less than elementary <input type="checkbox"/> Elementary School <input type="checkbox"/> Middle School <input type="checkbox"/> High School/GED <input type="checkbox"/> Trade School <input type="checkbox"/> 2 year college <input type="checkbox"/> 4 year college <input type="checkbox"/> Graduate/professional <input type="checkbox"/> Other Certificate
Needs: Do you have any problems getting any of the following: Food <input type="checkbox"/> No <input type="checkbox"/> Yes Utilities <input type="checkbox"/> No <input type="checkbox"/> Yes Transportation <input type="checkbox"/> No <input type="checkbox"/> Yes Medicine/Medical Care <input type="checkbox"/> No <input type="checkbox"/> Yes Health insurance <input type="checkbox"/> No <input type="checkbox"/> Yes Rent/Mortgage payment <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____
Housing: What is your housing situation today? <input type="checkbox"/> I have housing <input type="checkbox"/> I do not have housing Who do you live with? _____
Do you have any concerns for you or your family's safety <input type="checkbox"/> No <input type="checkbox"/> Yes _____

Patient Signature: _____ Date _____

Provider Signature: _____ Date _____