WELLSPRING FAMILY PRACTICE

Health History

Name _____ Date _____

Date of birth _____ Referred by _____

Are you under the care of any other physician/provider? ☐ Yes ☐ No

Please list other health care providers _____

SOCIAL HISTORY

Women Only

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

Men Only

Date of last prostate exam _____ Date of last PSA test _____

Date of last colonoscopy _____ Date of last Dexa Scan _____

LIFESTYLE

Exercise

What do you do? _____ How long? _____ How often? _____

Can you walk a block or climb a flight of stairs without getting short of breath? ☐ Yes ☐ No

Tobacco Use

Do you currently use any forms of tobacco? (please specify what type) _____

If yes, how frequently is your usage? _____ Are you interested in quitting? ☐ Yes ☐ No

If no, do you have a history of tobacco use? ☐ Yes ☐ No

Alcohol

How many drinking days do you have per week? _____ On average, how many drinks per drinking day? _____

Have you had more than 4 drinks a day in the past 3 months? ☐ Yes ☐ No

Are you or others concerned about your drinking? ☐ Yes ☐ No

Falls

Have you fallen in the past year? ☐ Yes ☐ No

Do you have problems with walking or balance? ☐ Yes ☐ No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? ☐ Yes ☐ No

Do you regularly wear a seatbelt? ☐ Yes ☐ No

A part of allcare Medical Group

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WELLSPRING FAMILY PRACTICE

Health History *(continued)*

HIV Testing

Would you like HIV testing? ☐ Yes ☐ No (If yes, please tell the nurse). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Caffeine

How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) _____

Birth Control

Method (if applicable): _____

Sleep

Do you stop breathing during sleep or have concerns about sleep apnea? ☐ Yes ☐ No

Depression Screen

Recently, have you been bothered by little interest or pleasure in doing things, or feeling down, hopeless, or depressed? ☐ Yes ☐ No

Medications

Medications *(please list all)*	Dose *(Mg., pill, etc.)*	Times Per Week

(If you need more room to list additional medications, please write them on a blank sheet of paper with the required information)

Do you have any trouble taking any of your medications? ☐ Yes ☐ No

Allergies

Allergies *(environmental, food, drug)*	Reaction *(symptoms)*	Severity

(If you need more room to list additional allergies, please write them on a blank sheet of paper with the required information)

Bladder Control

Do you lose control of your urine to the point you would like to know how to treat it? ☐ Yes ☐ No

WELLSPRING
FAMILY PRACTICE

Health History *(continued)*

PAST MEDICAL HISTORY (check all that apply)

- ☐ Cancer (type and location) _____
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Heart malformations
- ☐ Heart muscle disorders
- ☐ High blood pressure
- ☐ Hypothyroidism
- ☐ Other _____
- ☐ Coronary artery disease
- ☐ Heart infections/inflammation
- ☐ Heart rhythm
- ☐ Psychiatric condition

Diabetic Patients

Date of last foot exam _____ Date of last eye exam _____

Date of last A1c _____ Date of last cholesterol panel _____

PREVIOUS SURGERIES

	Type	Year	Surgeon	City
1				
2				
3				
4				

FAMILY HISTORY

Father (if living) Age _____ Health _____

Mother (if living) Age _____ Health _____

Father (if living) Age of Death _____ Cause _____

Mother (if living) Age of Death _____ Cause _____

Children

of Children _____ # living _____ # deceased _____ Ages of each _____

Serious illnesses of children

FAMILY MEDICAL HISTORY (Please check and note relationship. If grandparent, please specify paternal.)

- ☐ Cancer (type and location) _____
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Heart malformations
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