Annual Wellness Exam

Name:_____DOB:_____Today's Date:_____

REVIEW OF SYSTEMS: Are you **CURRENTLY** experiencing any of the following symptoms:

Urinary Frequency	Abnormal Urine Stream	Change in Bowel Habits	Muscle Weakness	Urinary Burning
Fatigue	Hoarseness	Headaches	Sinusitis	Wheezing
Hot Flashes	Night Sweats	Weight loss/gain	Change in Skin Lesions	Change in Moles
Change in Vision	Decrease in Hearing	Ringing in the Ears	Chronic cough	Wheezing
Breast Mass	Breast Pain	Nipple Discharge	Penial Discharge	Vaginal Discharge
Chest Pain	Leg pain	Leg Swelling	Palpitations	Shortness of Breath
Abdominal Pain	Pain when Urinating	Constipation	Fainting	Black/Tarry Stool
Rectal Bleeding	Frequent Urination	Dizziness	Incontinence	Irregular periods
Anxiety	Joint Pain	Joint Swelling	Sleep Changes	Depression
Sexual Dysfunction	Easy Bruising	Enlarged Nodes or Glands	Testicular Mass	Testicular Pain
Erectile Dysfunction	Suicidal Ideation	Feeling of Hopelessness	Changes in Speech	Blood in Urine

Social History

Alcohol Use: **NONE** **1-2 drinks/week** **3-5 drinks/week** **More than 6 drinks per week**

Exercise: **NONE** **1-2 times/week** **3-5 times/week** **More than 6 days per week**

Type(s) of exercise:_____

Tobacco Use: **NONE** **1-2 times/week** **3-5 times/week** **More than 6 times per week**

How many packs per day/week_____ Are you interested in quitting:_____

Do you JUUL or Vape: YES NO Frequency:_____

(TURN OVER)

Are you **currently** using:

Marijuana Cocaine Speed Ecstasy Other Drug:_____

Frequency:_____

Do you have a **history** of using any of the following:

Marijuana Cocaine Speed Ecstasy Other Drug:_____

Frequency:_____

When was the last time you used any of these drugs:_____

Current Occupation:_____ Full Time Part Time

Are you currently a student: _____Major:_____School:_____

Current household members-Name and relation to you.

Safety

Do you wear seatbelts in the car?_____

Do you have active smoke detectors in your home?_____

Do you wear a helmet when riding a bike or motorcycle?_____

Do you have guns in the home?(optional)_____

If you do have guns, are they safely secured:_____

Sexual Activity

Are you currently active?_____ New partner?_____Using condoms?_____

Other forms of birth control used:_____

Sexual Preference: Male Female Both

Do you identify as: Male Female Nonbinary Gender Fluid Other:_____

Pregnancy History

Number of pregnancies_____ Number of live births_____Number of miscarriages/abortions_____

Date of last menstrual period (First day):____/_____/_____

Routine Health Maintenance- Please list exam date and result if possible

Cholesterol Test	Self-breast exam
Colon Cancer Screening- Stool card or Colonoscopy?	Last eye exam: Do you wear corrective lenses?
Mammogram	PAP Smear:
Prostate Cancer Screening (PSA blood test)	Bone Density:
Dental Exam:	Tetanus Booster:
Pneumonia Vaccine:	Shingles Vaccine:

Family History- Please note whether on the Mother or Father's side of the family.

Alcohol Abuse	Diabetes	Ovarian Cancer
Brain Cancer	Heart Disease/Attack	Prostate Cancer
Benign Prostate Enlargement	High Cholesterol	Rheumatoid Arthritis or Lupus
Breast Cancer	High Blood Pressure	Stomach Cancer
Cervical or Uterine Cancer	Lung Cancer	Stroke
Colon Cancer	Melanoma	Testicular Cancer
Depression	Osteoporosis	Thyroid Cancer
Thyroid Disease	Tuberculosis	Other:

Preferred Pharmacy: Local:_____Phone Number_____

Mail Order:_____Phone Number_____

Current List of Medication-Please provide your current medications and their doses.

Vitamins and Over the Counter vitamins or supplements-Please provide name and dose.

(TURN OVER)

Allergies- Please list all your medication allergies and the reaction you have.

Are you allergic to shellfish or iodine?_____Reaction:_____

Are you allergic to latex?_____Reaction:_____

Have you been hospitalized since your last physical:_____If yes, please list below.

Have you had any surgeries since your last physical:_____If yes, please list below.

Please list the name and phone number of any other health or mental wellness providers you are currently under the care of:
