WELL ADULT QUESTIONAIRE

(All patients age 19-65 presenting for well exam)

UPDATES IN LAST YEAR - MEDICAL / SURGICAL HISTORY

UPDATES IN LAST YEAR - FAMILY HISTORY

NUTRITION & EXERCISE *(briefly describe diet and exercise level)*

PREVENTION

	month & year		
Cholesterol	_____	Dental check-up in last year?	_____
Pap Smear	_____	Flu Shot in last year?	_____
Mammogram	_____	Tetanus/Tdap in last 10 years?	_____
Prostate Evaluation	_____	Pneumonia vaccine?	_____
Colonoscopy / Stool Blood Test	_____	Shingles (Zoster) vaccine?	_____

ADDITIONAL TESTING

Do you desire STD testing YES NO

MOOD

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	None	*several days*	*more than half*	*nearly every day*
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

SYMPTOMS

Fever / chills	YES	NO	Fatigue	YES	NO
Visual changes	YES	NO	Eye irritation	YES	NO
Hearing loss	YES	NO	Ear Pain	YES	NO
Chest pain	YES	NO	Palpitations	YES	NO
Cough	YES	NO	Wheeze	YES	NO
Stomach pain	YES	NO	Bowel changes	YES	NO
Urinary problems	YES	NO	Low libido	YES	NO
Joint pains	YES	NO	Joint swelling	YES	NO
Rash	YES	NO	Concerning lesions	YES	NO
Headaches	YES	NO	Confusion / memory loss	YES	NO

Women turnover and complete well woman questionnaire →

Wellness Exams / Physicals are intended to address only preventive care. Most commercial & federal insurance providers **WILL NOT COVER** evaluation of new medical conditions. As such, new concerns/problems may be assessed an additional charge.

WELL WOMAN QUESTIONAIRE

MENSTRUAL HISTORY

Date of last period _____

Cycle length _____ REGULAR IRREGULAR

Period length _____ LIGHT MODERATE HEAVY

Bleed between periods YES NO

OB/GYN HISTORY

	month / year	*treatment / therapy / result*
Abnormal pap smear?	_____	_____

Pregnancies: _____ Abortions/Miscarriages: _____ Living Children: _____

Gestational Diabetes? YES NO

Complications? YES NO _____

SYMPTOMS

Breast Pain	YES	NO	History of migraines	YES	NO
Severe menstrual pain	YES	NO	Hot flashes	YES	NO
Problems with libido	YES	NO	Vaginal discharge	YES	NO
Do you feel safe at home	YES	NO	History of abuse	YES	NO

Are you interested in birth control?	YES	NO
Are you planning to become pregnant in next year?	YES	NO