WELLMED

HEALTH MAINTENANCE INFORMATION

Patient name:______________________________ Date of birth:______________

Medications – List all medications you currently take, the dosage, and how often you are taking them Include all prescription and non-prescription (over-the counter, vitamins, supplements) medications					
☐ I do not take any medications					
Medication Name	**Dose**	**Directions**	**Medication Name**	**Dose**	**Directions**

Medication and Food Allergies – List all known allergies and/or sensitivities (drugs, food, animals, etc.)	
☐ No known allergies and/or sensitivities	

Health Maintenance – Check all that apply and provide the date and where it was most recently completed					
Exam	**Date**	**Doctor/Facility**	**Exam**	**Date**	**Doctor/Facility**
☐ Stool Blood Test			☐ Hepatitis C Screening		
☐ Colonoscopy (colon or rectal cancer test)			☐ Mammogram (breast cancer test)		
☐ DEXA Scan (bone scan)			☐ Pap Test (cervical cancer test)		
☐ Echocardiogram (heart ultrasound)			☐ Breast Exam		
☐ Pulmonary Function Test (lung test)			☐ Pneumonia Vaccine		
☐ Exercise Test (heart stress test)			☐ Influenza Vaccine		
☐ Eye Exam			☐ Shingles Vaccine		
☐ Foot Exam			☐ Tetanus Vaccine		

Medical History – Please list any known health conditions and the date you were diagnosed			
Date	**Health Condition**	**Date**	**Health Condition**

Do you have an Advance Directive? ☐ Yes ☐ No

Do you have a Medical Power of Attorney? ☐ Yes ☐ No

Do you have a Living Will? ☐ Yes ☐ No

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Surgical/Hospitalization History – Please list any previous surgeries and/or hospitalizations and the date they occurred

Date	Surgery/Hospitalization	Date	Surgery/Hospitalization

Family History – If Parent (P), Siblings (S), Children (C), or Grandparent (GP) had any of the following, please indicate relative relationship

☐ Diabetes	Relative:	☐ Heart Disease/Attack	Relative:
☐ Cancer	Relative:	☐ Heart Failure	Relative:
☐ Glaucoma	Relative:	☐ Kidney Disease	Relative:
☐ High Blood Pressure	Relative:	☐ Stroke	Relative:
☐ High Cholesterol	Relative:	☐ Other	Relative:

Work History – Please list any potential exposures you might have encountered during your work, military, or volunteer history

		Duration in Years
Occupation		
Military Service & Occupation Specialty		
Volunteer Service		
Exposure	☐ Toxic chemicals (paint, fuels, fertilizers, pesticides, weed killer, cleaning agents, lead, arsenic, chloroform, solvents)	
	☐ Radiation (X-ray, atomic weapon production/testing/use, nuclear waste)	
	☐ Respiratory (gas, fumes, dust, asbestos)	
	☐ Biological materials (blood, bodily fluids)	
	☐ Combat	
	☐ Agent Orange	
	☐ Contaminated water	
	☐ Excessive noise and/or vibration (aircraft, construction, factory)	
	☐ Excessive sun (farming, ranching, construction)	
	☐ Excessive or long-term stress	
	☐ Other	

Social History

Have you ever smoked? ☐ Yes ☐ No If yes, for how many years?______ Quit date:______________

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs do you smoke a day? ______________

Do you vape? ☐ Yes ☐ No If yes, how often? Daily______ Weekly______ Monthly______

Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks do you consume in a day? ____________

If yes, how many drinks do you consume in a week?____________