Eagle Family Medicine @Village Wellness History

Name_____ Date _____

Age_____ Marital Status: S M Sep D W Partner

Do you have questions or concerns to discuss with your provider today?

_____

_____

Health Maintenance-please give the date of:

Last dental exam:_____ Last eye exam:_____

Colon cancer screening:_____

Last tetanus?_____ Pneumonia shot?_____

Flu shot?_____ Have you had a shingles shot?_____

For Women:

Last PAP smear:_____ Who did your last PAP smear?_____

Last mammogram:_____ Sexually active?_____

Last menstrual period:_____ Birth control method:_____

For Men:

Last prostate exam:_____ PSA blood test:_____

Sexually active?_____

Health Habits

Do you smoke?_____ If so, how much?_____ If ex-smoker give quit date_____

How many alcoholic beverages (beer, wine or liquor) do you drink each week?_____

How much caffeine do you drink each day? (coffee, tea, soda, energy drinks)_____

Do you get vigorous exercise outside of your job at least 3 times per week? _____

Since your last complete exam, do you have symptoms that concern you related to any of the following?

Frequent or severe headache, vision or hearing problems	Yes No	_____
Hay fever, allergies, wheezing	Yes No	_____
Problems with digestion or bowels	Yes No	_____
Chest pain or tightness, palpitations	Yes No	_____
Change in exercise tolerance	Yes No	_____
Shortness of breath or persistent cough	Yes No	_____
Joint pain or swelling, injuries	Yes No	_____
New rashes or skin lesions	Yes No	_____
Anxiety, change in mood, or sleep problems	Yes No	_____
Reproductive, urinary, or sexual concerns	Yes No	_____

Any new medicines, ER Visits, hospitalizations, surgeries, or change in family history not noted elsewhere?

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