Adult Well Visit Form

Date: _____

Patient Infomation

Name: _____ Date of Birth: _____

Last *First* *M.I.*

Preferred **Local** Pharmacy:	
Preferred **Mail Order** Pharmacy:	

Social History

Marital Status (please Choose One):	Single	Married	Divorced	Separated	Widowed
Who do you currently Live with:	Alone	Family	Friends	Significant Other	
Current Job/Location:					
What kind of exercise do you do? How many minutes per week:					
Have you seen another Physician in the last year? If yes, who and where?					
Do you wear Seatbelts? Yes No	Do you wear Sunscreen? Yes No		Do you text while Driving? Yes No		
Do you drink coffee/ soda/tea? Yes/No	If yes, how many cups/cans a day?				
Alcohol Use:	Never	Rarely	Moderate	Daily	
Tobacco Use:	Never Quit Currently Smoke If currently smoke how many packs per day? _____ Year began smoking? If quit, Year quit?				
Have you had an injury at work in the last year?					
What type of Birth Control is used between you and your partner?					

Current Medications

Please include all prescriptions, over the counter, vitamins and supplements you are currently taking

Name/Dose of Medication	Reason for taking Medication

Recent Surgeries/Hospitalizations

Please list date and details of any surgery/hospitalization in the LAST YEAR

Date	Reason/Details

Severe Injuries

Please list dates and details of any injuries you have had in the LAST YEAR

Date	Details

Social Determinants

In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food?	YES NO
In the last 12 months has your utility company shut off your service for not paying your bills?	YES NO
Are you worried in the next 2 months you may not have stable housing?	YES NO
Do problems getting child care make it difficult for you to work or study? (leave blank if you don't have children)	YES NO
In the last 12 months have you needed to see a doctor but could not because of cost?	YES NO
In the last 12 months have you ever had to go without healthcare because you didn't have a way to get there?	YES NO
Do you ever need help reading hospital materials?	YES NO
Are you afraid you might be hurt in your apartment building or house?	YES NO
If you checked YES to any above, would you like to receive assistance with any of these needs?	YES NO
Are any of these needs urgent? For example: I don't have food for tonight, I don't have a place to sleep tonight.	YES NO

Over the past two weeks, how often have you experienced any of the following concerns?	Not at all	Several Days	More than half the days	Nearly everyday
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				

Present Medical History

Do you CURRENTLY have any issues with the following? (Please circle Yes or No)

Fatigue	YES	NO
Fever	YES	NO
Weight gain >10 lbs.	YES	NO
Weight loss >10 lbs.	YES	NO

Change in wart or mole	YES	NO
Itching	YES	NO
New Lesions	YES	NO
Rash	YES	NO

Headache	YES	NO
Visual Disturbances	YES	NO
Hearing Loss	YES	NO
Frequent Colds	YES	NO
Bleeding gums	YES	NO
Hoarseness	YES	NO

****Continued on next page****

Neck Stiffness	YES	NO
Swollen Glands	YES	NO
Cough	YES	NO
Difficulty Breathing	YES	NO
Wheezing	YES	NO

Breast Mass	YES	NO

Elevated Blood Pressure	YES	NO
Chest Pain	YES	NO
Rapid Heart Beat	YES	NO
Shortness of Breath	YES	NO
Swelling of Limbs	YES	NO

Abdominal Pain	YES	NO
Change in bowel habits	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Difficulty Swallowing	YES	NO
Heartburn	YES	NO
Rectal Bleeding	YES	NO

Calf pain	YES	NO
Joint pain	YES	NO
Muscle Cramps	YES	NO

Dizziness	YES	NO
Weakness	YES	NO

Anxiety	YES	NO
Depression	YES	NO

Intolerance to cold temperatures	YES	NO
Excessive Thirst	YES	NO
Excessive Urination	YES	NO

Easy Bruising	YES	NO
Gland problems	YES	NO
Excessive Bleeding	YES	NO
Male Only		
Difficulty Urinating	YES	NO
Impotence	YES	NO
Urinating during night	YES	NO
Testicular Mass	YES	NO
Penial Discharge	YES	NO
Urgency of Urination	YES	NO
Female Only		
Absence of Menstruation	YES	NO
Pain with Sex	YES	NO
Pain with Urination	YES	NO
Frequency of Urination	YES	NO
Loss of bladder control	YES	NO
Menstrual issues	YES	NO
Pelvic Pain	YES	NO
Vaginal Bleeding (other than menstrual)	YES	NO
Vaginal Discharge	YES	NO