WHCC Preventive Health Visit – Established Patient

Please complete this form for your “annual exam” or preventive visit
unless you are here for a Medicare Wellness Visit, which requires a different form.

Thank you for coming in for this visit!
- Most health plans cover your annual preventive visit, screening tests, & vaccines at no cost to you.
- Insurance plans consider preventive visits as separate & different from all other health care visits.
- At a preventive visit we’ll do the following (based on your age, sex, medical history & family history):
  - Review standard screening tests and preventive measures recommended for you
  - Do, order, or plan screening tests & measures advised for you, that you wish to do
  - Discuss basic health advice that could help you stay as healthy as possible in the long run
- As part of this visit, we can refill ongoing medications that we’ve prescribed for you before.

Preferred name (first & last): ___________________________  Preferred pronouns: ___________

Date of Birth: _________________  Age: ______  Gender: _____________________

Do you need any medication refills today?  Yes ☐  No ☐
Do you feel your diet is healthy?  Yes ☐  No ☐  Okay but could be better ☐
Do you get regular exercise?  Yes ☐  No ☐
  What kind of exercise?  _____________________________________________________
  How long each time, & how often?  ____________________________________________

Do you wear seat belts?  Yes ☐  No ☐
Does your home have smoke detectors?  Yes ☐  No ☐
In the past year, has anyone threatened you or physically hurt you?  Yes ☐  No ☐
Is there a gun in your home?  Yes ☐  No ☐  Decline to state ☐
  If Yes, there is a gun in your home, is it stored safely?  Yes ☐  No ☐  Decline to state ☐

Have you had any recent unexplained breast lump or pain?  Yes ☐  No ☐
Are you having any other symptoms that you’re concerned about?  Yes ☐  No ☐
  If yes, please describe (and please be aware that evaluating or treating a new or significant problem may need a separate visit, or may result in a problem-visit charge at today’s appointment):

Please answer these questions if they apply to you:  ☐ These questions don’t apply to me

Would you like to become pregnant in the next year?  Yes ☐  No ☐  Not sure ☐
Would you like to talk about birth control options today?  Yes ☐  No ☐
Would you like testing for sexually transmitted diseases today?  Yes ☐  No ☐
Would you like testing for HIV today?  Yes ☐  No ☐

*Note that screening for Chlamydia and gonorrhea, and/or HIV, may be recommended for you based on standard guidelines, even if you are at low risk*

Please complete both sides of this form
Are you having periods?  ☐ Yes  ☐ No
If yes:  Are your periods regular?  ☐ Yes  ☐ No
How far apart?  ___________________ days
How heavy?  Light ☐ Moderate ☐ Heavy ☐
If no periods, please circle the reason:
Menopause  Hysterectomy  Pregnant  Breastfeeding
IUD/implant  Pill/Ring  Other or Unknown  Transgender

Please let us know about any changes in the past year (or since your last visit here) in these areas:
New medical conditions: ________________________________________________________________
Surgeries: __________________________________________________________________________
Changes in family medical history: _______________________________________________________
Pregnancies or deliveries: __________________________________________________________________
Changes in job, school, or living situation: __________________________________________________
Screening tests or vaccines outside of UWMC: _______________________________________________

Do you use tobacco?
Never ☐ / In the past ☐ Quit date _____ / Current ☐ # of packs per day _____ # of years _____
Do you use marijuana?  ☐ Yes  ☐ No  ☐ Decline to state  ☐ If yes: How often ______________
Do you use other drugs?  ☐ Yes  ☐ No  ☐ Decline to state  ☐ If yes: How often ____________
Are you sexually active?  ☐ Yes  ☐ No  ☐ Not currently ☐
Partners: Women ☐ Men ☐ Transwomen ☐ Transmen ☐ # of partners in past year: ___________
Birth control method(s) if applicable: ______________________________________________________

Over the last 2 weeks how often have you been bothered by the following?
• Little interest or pleasure in doing things:
  Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐
• Feeling down, depressed, or hopeless:
  Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐
How many times in the past year have you had 4 or more drinks containing alcohol on one occasion?
  Never ☐ Less than once a month ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐
How often do you have a drink containing alcohol?
  Never ☐ / Monthly or less ☐ / 2-4 times a month ☐ / 2-3 times a week ☐ / >4 times a week ☐
How many standard-size drinks containing alcohol do you have on a typical day?
  None to less than 1 ☐ / 1-2 ☐ / 3-4 ☐ / 5-6 ☐ / 7-9 ☐ / 10 or more ☐
Have you fallen down in the past year?  ☐ Yes  ☐ No
Are you afraid of falling?  ☐ Yes  ☐ No
Any issues with balance, walking, or feeling unsteady?  ☐ Yes  ☐ No
Do you feel safe at home?  ☐ Yes  ☐ No

Patient Signature ____________________________  Patient Name (printed) ___________________ Date Completed ____________

Please complete both sides - Thank you!

Provider Signature ____________________________  Provider Name (printed) ___________________ Date Reviewed ____________

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