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

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Neighborhood Clinics – Valley Medical Center
University of Washington Physicians Seattle, Washington

PREVENTIVE HEALTH VISIT

U3646

UH3646 REV JAN 20

Are you having periods? Yes ☐ No ☐

If yes: Are your periods regular ? Yes ☐ No ☐

How far apart? _____ days

How heavy? Light ☐ Moderate ☐ Heavy ☐

Office use only:
MA initials _____

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

PLACE PATIENT LABEL HERE