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, 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 ___________________________

Provider Signature ___________________________  Provider Name (printed) ___________________________  Date Reviewed ___________________________

Please complete both sides - Thank you!