Annual Wellness Physical

Name:_______________________________ Date of Birth:_______________________

List any Doctor you see regularly:	Reason:	Month/year of last appointment
____	_______________________	___________________________
____	_______________________	___________________________
____	_______________________	___________________________
____	_______________________	___________________________

Are you a current (or former) smoker? Yes No

How many years have you smoked? _____________________

Average number of packs you smoked per day? _____________________

Have you ever had colon cancer screening (colonoscopy)? Yes No

Date:____________________ Physician or clinic:_______________________________________

Have you ever been tested for hepatitis liver infection or HIV? Yes No

Date:_____________________ Physician or clinic: ______________________________________

List any immunizations you have at another clinic/ER/pharmacy: Date:

____ _______________

____ ________________

Over the last 2 weeks how often have you been bothered by the following problems? (circle your answer)

0=Not at all   1=Several Days   2=More than half the days   3=Nearly every day

0 1 2 3   1. Little interest or pleasure in doing things?

0 1 2 3   2. Feeling down, depressed, or hopeless?

0 1 2 3   3. Trouble falling/staying asleep, or sleeping too much?

0 1 2 3   4. Feeling tired or having little energy?

0 1 2 3   5. Poor appetite or overeating?

0 1 2 3   6. Feeling bad about yourself-or that you are a failure or have let someone down?

0 1 2 3   7. Trouble concentrating on things, such as reading the newspaper or watching tv?

0 1 2 3   8. Moving or speaking so slowly that other people have noticed. Or the opposite-

Being fidgety or restless a lot more than usual.

0 1 2 3   9. Thoughts that you would be better off dead, or of hurting yourself in some way.

If you circled ANY problems, how DIFFICULT have these problems made it for you to do your work,

take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	very difficult	extremely difficult
☐	☐	☐	☐

MEN'S HEALTH

You may skip the section below if you completed this form previously and it is unchanged.

Do you have a family history of prostate cancer?   Yes   No

If yes, what is the relation to you?____________________________ How old were they?______________

WOMEN'S HEALTH

You may skip the section below if you see an OB/GYN for annual wellness exam,

or if you have completed this form previously and it is unchanged.

________________Age when you had your first menstrual period

________________If you have been pregnant, age you were at the time of your first pregnancy

________________Date of your last menstrual period (the first day of your last period)

________________ Date of your last mammogram

________________Date of your last pap smear

Any previously abnormal pap smear? Yes No

Have you had a hysterectomy? Yes No

Do you have a family history of breast cancer? Yes No

Relation to you:_________________________ Do they have "BRCA"? Yes No

Age at their diagnosis:____________________ Their current age:___________________

Do you have Ashkenazi ancestry? Yes No

Have YOU ever taken estrogen pills for menopause? Yes No

Have YOU ever had a biopsy of your breast? Yes No