Three Rivers
MEDICAL CLINIC

Adult Wellness Form

Please complete all pages as completely as possible. Answers will help providers understand medical concerns and conditions better.

_____ _____ Gender: □ Female □ Male

Patient Name Date of Birth

PRESENT HEALTH CONCERNS: _____

How would you describe your general health? □ Excellent □ Very Good □ Good □ Fair □ Poor

How much do the following problems bother you?	Yes	No
I feel good about myself.		
I can deal with my problems and can accomplish things I want.		
I feel controlled, afraid and/or fearful.		
I have been physically hurt and/or threatened.		
Feeling anything is an effort.		
My heart pounds and/or races.		
I have difficulty falling asleep or staying asleep.		
I have severe headaches.		
I have pain in my legs and/or joints.		
I have chest pain and/or shortness of breath.		
I have stomach pain and/or heartburn.		
I wake frequently in the night to urinate or have difficulty with urine stream strength/flow rate.		
I have noticed a change in size/firmness in stools.		
I have difficulty hearing and/or need others to repeat what they've said.		
My family and/or I have noticed that I am having memory problems.		
I have problems with walking, falling and/or balance.		
I have noticed a change in size/color of a moles).		
I have noticed a change, new or enlarged lump in my breast.		
Other:		

Women Only. **OB-GYN HISTORY**

Total Number of Pregnancies: _____

Number of: Vaginal Births: _____ C-Sections: _____ Miscarriages: _____ Ectopics: _____ Abortions: _____

Patient: _____ Date of Birth: _____

SOCIAL HEALTH:

SUBSTANCES	Yes	No
I use tobacco products.		
I drink alcohol.		
I use recreational drugs.		
Other:		
SEXUALITY	**Yes**	**No**
I am sexually active.		
I have a hard time completing intercourse, getting/keeping an erection, etc.		
My partner and I are planning to get pregnant in the next year.		
Other:		

EXERCISE

Activity: _____ Time/Duration: _____ minutes _____ days per week.

Exertion: □ Stroll □ Mild □ Heavy □ I am not generally active

PREVENTATIVE MAINTENANCE:

	Yes	No
I have a signed Living Will.		
I have an up-to-date Durable Power of Attorney for health care.		
I have had a tetanus shot in the past 10 years.		
I have had at least one of the HPV vaccinations.		
I have had at least one of the pneumococcal vaccinations.		
Other:		

What was the MONTH and YEAR of your last:

Bone Density: _____ □ Normal □ Abnormal □ Never

Colonoscopy: _____ □ Normal □ Abnormal □ Never

Eye Exam: _____ □ Normal □ Abnormal □ Never

Dental Exam: _____ □ Normal □ Abnormal □ Never

Women only:

Mammogram: _____ □ Normal □ Abnormal □ Never

Pap Smear Test: _____ □ Normal □ Abnormal □ Never

If abnormal, did you have a colposcopy? □ Yes □ No

Men only:

Prostate Exam: _____ □ Normal □ Abnormal □ Never