

* This 6-page form takes about 15 minutes to complete. If you are unsure of any areas, it is fine to leave them blank and you may discuss it with your physician.

Please return this form to:

Fax: 608-662-2488

Mail: UW Health Welcome Center, 8007 Excelsior Drive, 9740WC, Madison, WI 53717

Today's Date: _____ **Phone Number:** _____

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____

Marital Status: Single Married Divorced Widowed

Education (# of years): _____ **Occupation:** _____

Advanced Care Planning: Do you have a Health Care Power of Attorney? Yes No

 Do you have a Living Will? Yes No

If yes, please bring a copy to your 1st appointment.

Present Medical Concerns:

None

Issue(s) you would like addressed at your first appointment:

None

** A nurse may call you to assist with your specific concerns or to help you make an appointment.*

Allergies: (Food and/or Medication) List specific allergen and specific reaction (e.g. Amoxicillin causes hives and itching):

None

Name: _____ Date of Birth: _____

Medications: Prescription and over-the-counter taken on a CONSISTENT basis (e.g. Ranitidine 150 mg twice a day):
None

	<u>Medication</u>	<u>Dose</u>	<u>Directions/Time per day</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

Past Surgical History: List surgery, date, hospital/location. (e.g. wisdom tooth extraction; July 1, 2011; Dr. Molar):
None

Hospitalizations: List reason, date and hospital/location:
None

Tobacco Use: Never Smoked

Current *Every Day* Smoker: Yes, for _____ Years Packs per Day: _____

Current *Some Day* Smoker: Yes, for _____ Years Packs per Day/Week/Month: _____

Exposure to Secondhand Smoke: Yes, for _____ Years

Former Smoker: Yes, for _____ Years Date Quit: _____

Comment(s):

If answered yes to Tobacco Use or Exposure, please check all that apply:

Cigarettes: Chew: Cigars:
Pipe: Snuff:

Name: _____ Date of Birth: _____

Alcohol Use: No

Yes Type: _____ Drinks per week: _____

Comment(s): _____

Illicit Drug Use: No

Yes Type: _____ Times per week: _____

Comment(s): _____

Sexual Activity:

Partners: Male(s) Female(s) Not Currently: Yes No

Birth Control or Other Contraception: _____

Comment(s): _____

Are you currently, or have you ever been, in a relationship where you were physically hurt, threatened, pressured to have sexual contact or made to feel afraid?

Currently: Yes No In the Past: Yes No

Pregnancy History:

N/A

Currently Pregnant: Yes No

Total # of Pregnancies: _____ Total # of Living Children: _____

Full-term Births: _____

Premature (under 37 weeks): _____ Ectopic: _____ Miscarriage: _____ Abortion: _____ Stillborn: _____

Activities of Daily Living

Military Service: No Yes Special Diet: No Yes

Blood Transfusion: No Yes Back Care: No Yes

Caffeine Concern: No Yes Exercise: No Yes

Use per week: _____ Type: _____

Occupational Exposure: No Yes Times per week: _____

Hobby Hazards: No Yes Bike Helmet: No Yes

Sleep Concern: No Yes Seatbelt: No Yes

Weight Concern: No Yes Self-Exams (Breast, Testicular): No Yes

Name: _____

Date of Birth: _____

Tests:

Date of last Mammogram: _____

Where performed? _____ or N/A

Date of last Colonoscopy: _____

Where performed? _____ or N/A

Date of last Pap Smear: _____

Where performed? _____ or N/A

Date of last Bone Density: _____

Where performed? _____ or N/A

Personal Current/Past Medical History

		<u>Year Diagnosed</u>	<u>Comment</u>
Breast Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Ovarian Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Uterine Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Colon Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Prostate Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Other Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	Type(s): _____
High Blood Pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Stroke/CVA	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Heart Disease/Attack	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
High Cholesterol	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	List Type 1 or 2: _____
Thyroid Disease	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Alcohol Dependency	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Drug Dependency	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Depression	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Anxiety	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Other Psychiatric Concerns	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Memory Concerns	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Allergies	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Asthma	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Osteoporosis	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Sickle Cell Disease	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	_____
Autoimmune Disease	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	Type: _____
Aneurysm	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____	Location: _____
Other _____		_____	_____

Name: _____ Date of Birth: _____

Are you adopted?

No Please check the box associated with family members who currently have or have had the following medical conditions.

Yes If history known of any blood relatives, please check the appropriate boxes below.

Be sure to complete front and back of this form.

Relationship:	Name:	STATUS: Alive Deceased (Please circle)	Hypertension	Coronary/Heart	Aneurysm	Stroke/CVA	Cholesterol Disorder	Diabetes Mellitus	Thyroid Disease	Allergies/Asthma	Immunologic Disorder	Autoimmune Disease	Cancer Breast	Cancer Ovarian	Cancer Uterine	Cancer Colon	Cancer Prostate	Cancer Other	Gastrointestinal Disease	Kidney Disease
Father		A / D																		
Mother		A / D																		
Son(s):		A / D																		
		A / D																		
		A / D																		
Daughter(s):		A / D																		
		A / D																		
		A / D																		
Sister(s):		A / D																		
		A / D																		
		A / D																		
Brother(s):		A / D																		
		A / D																		
		A / D																		
Mom's Mother (Maternal Grandmother)		A / D																		
Dad's Mother (Paternal Grandmother)		A / D																		
Mom's Father (Maternal Grandfather)		A / D																		
Dad's Father (Paternal Grandfather)		A / D																		
Mom's Sister(s) (Maternal Aunt)		A / D																		
Dad's Sister(s) (Paternal Aunt)		A / D																		
Mom's Brother(s) (Maternal Uncle)		A / D																		
Dad's Brother(s) (Paternal Uncle)		A / D																		
Other		A / D																		

Name: _____ Date of Birth: _____

Relationship:	Name:	Strabismus / Lazy Eye	Deafness	Anemia	Bleeding Disorder	Sickle Cell Disease	Neurological Disorder	ADD/ADHD	Learning Disability	Depression	Anxiety	Psych-Other	Dementia	Alcohol/Drug	Osteoporosis	Other	Other	Unknown-FHx
Father																		
Mother																		
Son(s):																		
Daughter(s):																		
Sister(s):																		
Brother(s):																		
Mom's Mother (Maternal Grandmother)																		
Dad's Mother (Paternal Grandmother)																		
Mom's Father (Maternal Grandfather)																		
Dad's Father (Paternal Grandfather)																		
Mom's Sister(s) (Maternal Aunt)																		
Dad's Sister(s) (Paternal Aunt)																		
Mom's Brother(s) (Maternal Uncle)																		
Dad's Brother(s) (Paternal Uncle)																		
Other																		