PREMIERMED FAMILY AND SPORTS MEDICINE
Annual Wellness Visit Form 2022

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First/Last Name: _____
Date of Birth: ____/____/_____ Social Security #: _____ - _____ - _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Secondary Phone: _____
Email Address: _____

Marital Status: ▢Single ▢Married ▢Divorced ▢Widowed ▢Separated
Sex: ▢Male ▢Female Gender: _____ Pronouns: _____
Race: ▢White ▢Black or African American ▢American Indian or Alaska Native ▢Asian
▢Native Hawaiian or Pacific Islander ▢Decline
Ethnicity: ▢Hispanic/Latino ▢Not Hispanic/Latino ▢Decline

EMERGENCY CONTACT & CONSENT FOR DISCLOSURE

I agree that PremierMED Family & Sport Medicine may disclose my medical information to me and the following individual(s) in the event I am not physically present, including disclosures by telephone, voice mail, facsimile, e-mail, or regular mail. I agree to let certain individual(s) participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for PremierMED Family & Sport Medicine and/or staff to disclose my personal medical information to the following individuals.

Contact First/Last Name: _____
Relation: _____ Contact Number: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____

INSURANCE

Insurance: _____
Policy Number: _____ Group Number: _____
Policy Holder: _____ Relation to Patient: _____
Date of Birth: ____/____/_____ Policy Holder SSN: _____ - _____ - _____

Secondary Insurance: _____
Policy Number: _____ Group Number: _____
Policy Holder: _____ Relation to Patient: _____
Date of Birth: ____/____/_____ Policy Holder SSN: _____ - _____ - _____

OFFICE USE ONLY
SCANNED PICTURE ID: _____ SCANNED INSURANCE CARD: _____
ALL FORMS REVIEWED BY: _____

MEDICAL HISTORY (Leave blank if no past/current medical history)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

SURGICAL HISTORY (Leave blank if no surgical history)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you currently see any specialists? (Please list the name, specialty, and location.)

_____
_____
_____
_____

Do you need any referrals today? If so, please state the type of specialist and the reasoning for the referral. If you have the provider picked out please list that as well.

_____

CURRENT MEDICATIONS (Leave blank if not currently taking medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES/MEDICATION SIDE EFFECTS (Please list the agent/medication and reaction)

_____
_____
_____

SOCIAL HISTORY

Occupation: _____ Employer: _____

▢Retired ▢Homemaker ▢Student ▢Unemployed

Who lives with you?
▢Spouse/Partner ▢Children ▢Roommates ▢Parents ▢Other

Tobacco use (including cigars/vape/smokeless):
▢Current everyday ▢Current someday ▢Former smoker ▢Never used

Alcohol use (beer/wine/liquor):
▢1-3 ▢4-6 ▢7+ per ▢Day ▢Week ▢Month ▢Year ▢No alcohol use

FEMALES
Currently menstruating: Date of last menstruation: ____/____/_____
▢Normal cycles ▢Abnormal cycles, please explain: _____

No longer menstruating:
▢Natural menopause ▢Hysterectomy Date ____/____/_____ ▢Other _____
Are you breastfeeding or pregnant? ▢Yes ▢No

Are you using any type of birth control?
If yes, what kind and when did you start using it?_____
If not, are you interested in discussing birth control options during your visit? ▢Yes ▢No
Date of last PAP smear: ____/____/_____ Date of last mammogram: ____/____/_____

MALES
Date of last prostate exam: _____
Have you noticed any testicular pain or lumps/bumps? ▢Yes ▢No
If so, location _____ how long as this been present?_____

ALL
Date of last ▢Colonoscopy ▢Cologuard ▢FOBT: ____/____/_____
Last DEXA scan: ____/____/_____
Last eye exam: ____/____/_____ Performing provider: _____
Last annual wellness exam: ____/____/_____ Performing provider: _____
How often do you exercise? _____
Do you eat a well-balanced diet? ▢ Yes ▢ No

Are you on any special diet or dietary restrictions? _____

VACCINATIONS

Shingles ▢Yes ▢No
Influenza ▢Yes ▢No
Pneumonia ▢Yes ▢No
Tetanus, Diphtheria, Pertussis (Tdap) ▢Yes ▢No
Hepatitis A ▢Yes ▢No
Hepatitis B ▢Yes ▢No
COVID19 ▢Yes ▢No

Are you interested in receiving any vaccines during today's visit? ▢Yes ▢No

FAMILY HISTORY

Father: ▢Living ▢Deceased
History of: ▢High blood pressure ▢Diabetes ▢ Cancer, type: _____ ▢Stroke
Other _____

Mother: ▢Living ▢Deceased
History of: ▢High blood pressure ▢Diabetes ▢ Cancer, type: _____ ▢Stroke
Other _____

Other significant family history: _____

PREFERRED PHARMACY

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____