

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")

	Social Security	· #:
Mailing Address:	_	
City:	State:	Zip Code:
		Phone:
Marital Status: □Single □Ma	urried Divorced D	Widowed □Separated
Sex: DMale DFemale Gend		
		erican Indian or Alaska Native □Asian
□Native Hawaiian or Pacific I		orioan malan or maona mativo molan
Ethnicity: DHispanic/Latino		o Decline
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		e. Therefore, I hereby give my permission for disclose my personal medical information to a
Contact First/Last Name: Relation:		lumber:
Relation:	Contact N	lumber:
Relation: Mailing Address:	Contact N	lumber:
Relation: Mailing Address: City: INSURANCE	Contact N State:	lumber:
Relation: Mailing Address: City: INSURANCE Insurance:	Contact N State:	lumber: Zip Code:
Relation: Mailing Address: City: INSURANCE Insurance: Policy Number:	Contact N	Group Number:
Relation: Mailing Address: City: INSURANCE Insurance: Policy Number:	Contact N	lumber: Zip Code:
Relation:	Contact N State: Policy Holder S	Group Number: Relation to Patient:
Relation:	Contact N State: Policy Holder S	Group Number: Relation to Patient:
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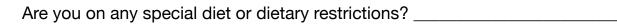
MEDICAL HISTORY (Leave blank if no past/current medical history)



1	6
2	7
3	8
4	9
5	10
SURGICAL HISTORY (Leave blank if no state of the state of	surgical history) 6 7 8 9 10.
Do you currently see any specialists? (Pleas	se list the name, specialty, and location.)
for the referral. If you have the provider pick	ase state the type of specialist and the reasoning ked out please list that as well.
CURRENT MEDICATIONS (Leave blank	_
1	6
2	/
3	8
4	9 10
5	10
ALLERGIES/MEDICATION SIDE EFFE	CTS (Please list the agent/medication and reaction)
SOCIAL HISTORY Occupation: Er	nployer:



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: No longer menstruating: No longer menstruating: No longer menstruating: 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





Shingles □Yes □No Influenza □Yes □No Pneumonia DYes 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

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FAMILY HISTORY			
Father: DLiving Dece	ased		
History of: □High bloo Other			
Mother: □Living □Dece	eased		
History of: □High blood Other			□Stroke
Other significant famil	y history:		
PREFERRED PHAR	MACY		
Name:		Phone:	
Address:			
City.	-	7ir	o Code: