Texoma Primary Care
Medical History and Wellness Form

Patient Name: **Date of Birth:**

Reason for today's visit:

E-mail:

Pharmacy:

Preventative Services (Please circle if you ever had any of the following)	
Bone Density/DEXA Scan	YES NO If yes, year completed _____ Normal/Abnormal
Colonoscopy/Cologuard	YES NO If yes, year completed _____ Normal/Abnormal
Cardiac Stress Test	YES NO If yes, year completed _____ Normal/Abnormal
Eye Exam	YES NO If yes, year completed _____ Normal/Abnormal
Dental Exam	YES NO If yes, year completed _____ Normal/Abnormal
CT Cardiac Calcium Score	YES NO If yes, year completed _____ Normal/Abnormal
CT Lungs (if patient has positive Smoking History)	YES NO If yes, year completed _____ Normal/Abnormal

For Male Patients Only:

PSA Test YES NO If yes, year completed _____ Normal/Abnormal

For Female Patients Only:

Mammogram YES NO If yes, year completed _____ Normal/Abnormal

Pap Smear YES NO If yes, year completed _____ Normal/Abnormal

Colposcopy YES NO If yes, year completed _____ Normal/Abnormal

Number of Pregnancies: _____ Number of Live Births _____

Date of Last Menstrual Cycle: _____Method of Birth Control: _____

Please list any new MEDICAL CONDITIONS since last visit and name of specialist	

New SURGERIES/PROCEDURES since last visit with date and name of specialist	

Social History: (please circle one)				
Marital Status:	Single	Married	Divorced	Widowed
Occupation:				

Exercise Type/Length of Sessions/Number of Days Weekly:

Substance Use: (please circle one)
Tobacco Use: Cigarettes / Chewing Tobacco / Vape / Other _____ Current / Past Year Quit:_____ Packs Per Day/Åmount: _____
Caffeine Use: Type _____ Amount: _____
Alcohol Use: Never / Socially / Rarely Amount per day / per week:_____
Drug Use: Current / Past Type of Drugs: _____

FAMILY HISTORY								
	Heart Disease/Stroke	**High Blood Pressure**	**Mental Health Issues**	**Cancer and Type**	**Thyroid Disease**	**Autoimmune Disorders**	**Other Illness or Condition**	**Age**
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Siblings								

Changes to Medications or Reactions (since last visit)			
Medication	**Reason for Taking**	**Dosage**	**Frequency**

Immunization History (please circle yes or no and write the date last given)

Tetanus	yes/no Date: _____	Influenza	yes/no Date:_____
Pneumococcal	yes/no Date: _____	Shingles	yes/no Date:_____
Hepatitis A	yes/no Date: _____	Hepatitis B	yes/no Date:_____
Gardisil/HPV	yes/no Date: _____	COVID	yes/no Date:_____

Date: _____

Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
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 or 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 yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around 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.	0	1	2	3
Add the score for each column				

Total Score (add your column scores):

_____

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores):

_____

List any health concerns you would like to discuss here. We may not be able to address all of them today but will try:

_____

_____

_____

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