

# 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)**

<b>Marital Status:</b>	Single	Married	Divorced	Widowed
<b>Occupation:</b>	_____			

**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/Amount: \_\_\_\_\_

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: _____
Gardasil/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.

<b>PHQ-9</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
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
<b>Add the score for each column</b>				

**Total Score (add your column scores):**

\_\_\_\_\_

<b>GAD-7</b>	<b>Not at all sure</b>	<b>Several days</b>	<b>Over half the days</b>	<b>Nearly every day</b>
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
<b>Add the score for each column</b>				

**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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