Amethyst Medical Group

Integrative/Functional Primary Care Medicine

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## 

## “It’s not just about how sick you are. It’s about how well you can be!”

**Annual Wellness Exam Questionaire:**

\*Please update this form with any changes since your last Wellness Exam\*

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_**

1. **SOCIAL HISTORY:**

Living situation: Live alone: \_\_\_\_\_\_\_\_\_ or with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you now, or have you ever, smoked? If so explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much alcohol do you drink and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any history of illegal/prescription drug abuse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where were you born?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your highest level of education?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current/previous occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do for exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your diet like?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many caffeinated beverages do you drink?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List countries have you have visited?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your stress level? High Medium Low, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an advance directive? No Yes If yes, may we have a copy?

**2. IMMUNIZATIONS:** Please fill in the dates of last immunizations. If you prefer to not have immunizations,

please indicate.

Tetanus:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis A:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia Vaccine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yellow Fever:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zostavax (shingles): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. HEALTH MAINTENANCE:** Please fill in dates of last health maintenance procedures

Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bone Density:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap Smear (Females)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram: (Females)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate Exam (Males)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. REVIEW OF SYSTEMS: In the Past 3 months:** Do you have, or have you had, any of the following:

**General:** **Breast:**

Have you been in good general health ……. No Yes Discharge………………………… No Yes

Recent weight loss/gain……………………. No Yes Infection………………………….. No Yes

Sleeping Trouble ………………………….. No Yes Mass/lump………………………... No Yes

Fatigue……………………………………… No Yes

**Cardiac:**

**Skin:** Angina…………………………… No Yes

Acne……………………………………….. No Yes Chest pain………………………... No Yes

Rash………………………………………... No Yes Murmur ………………………….. No Yes

Dry skin/itching……………………………. No Yes Palpitations………………………. No Yes

Eczema ……………………………………. No Yes Shortness of breath………………. No Yes

Sores/growths……………………………… No Yes Swelling of extremities (arms/legs) No Yes

**Head-Eyes-Ears-Throat:** **Pulmonary:**

Blurry vision/double vision (please specify). No Yes Asthma No Yes

Cataracts…………………………………… No Yes Frequent cough No Yes

Contact lenses/glasses (please specify)…… No Yes Pain with breathing No Yes

Dizziness…………………………………… No Yes Wheezing No Yes

Ear problems (drainage, earache, etc)……... No Yes

Eye problems (drainage, infection etc……...No Yes **Neurological**:

Hearing loss………………………………... No Yes Seizures………………………….. No Yes

Loss of balance……………………………. No Yes Paralysis…………………………. No Yes

Neck stiffness……………………………… No Yes Memory loss……………………... No Yes

Loss of consciousness…………… No Yes

**Gastrointestinal:** Headaches………………………... No Yes

Abdominal pain……………………………. No Yes Dizziness/fainting spells…………. No Yes

Appetite change……………………………. No Yes

Blood in stool……………………………… No Yes **Vascular:**

Change in bowel habits……………………. No Yes Pain inlegs with walking………… No Yes Ulcers……………………………………… No Yes Varicose vein…………………….. No Yes

Constipation……………………………….. No Yes Phlebitis …………………………. No Yes

Diarrhea …………………………………… No Yes Swelling of legs………………….. No Yes

Gallbladder problems……………………… No Yes Abnormal bleeding or bruising…… No Yes

Indigestion/heartburn……………………… No Yes

Hemorrhoids or piles………………………. No Yes **Endocrine:**

Nausea/vomiting ………………………….. No Yes Hormone therapy ………………... No Yes

Rectal bleeding…………………………….. No Yes Thyroid problems ………………... No Yes

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_**

**Urologic:** **Ob-Gyn:**

Hot flashes…………………….…. No Yes Dribbling…………………………………… No Yes Mood swings………………….…. No Yes Urgency……………………………………. No Yes Any pain with periods…………..... No Yes

Dysuria (pain or burning with urination….. . No Yes Menopausal…………………….… No Yes

Frequent urination…………………………. No Yes (if yes, at what age\_\_\_\_\_\_\_\_\_\_\_\_\_ )

Incontinence……………………………….. No Yes Frequency of periods, every \_\_\_\_\_\_\_\_\_\_days Hematuria (blood in urine) …………………No Yes

History of stones ………………………….. No Yes

Infection…………………………………….No Yes

Nocturia (night time unrination)……………No Yes

Stress incontinence………………………... No Yes **Musculoskeletal**:

Urgency……………………………………..No Yes

Arthritis …………………………. No Yes

Joint pain………………………… No Yes

Joint swelling…………………….. No Yes

Other pains……………………….. No Yes

Please include any other information that we should be aware of:

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