UW Health

* This 6-page form takes about 15 minutes to complete. If you are unsure of any areas, it is fine to leave them blank and you may discuss it with your physician.

Please return this form to:
Fax: 608-833-0298
Mail: UW Health Welcome Center, 8007 Excelsior Drive, 9740WC, Madison, WI 53717

Today's Date: _____ **Phone Number:** _____

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Education (# of years): _____ **Occupation:** _____

Advanced Care Planning: Do you have a Health Care Power of Attorney? Yes ☐ No ☐

Do you have a Living Will? Yes ☐ No ☐

If yes, please bring a copy to your 1st appointment.

Present Medical Concerns:
None ☐

_____

_____

_____

Issue(s) you would like addressed at your first appointment:
None ☐

_____

_____

_____

** A nurse may call you to assist with your specific concerns or to help you make an appointment.*

Allergies: (Food and/or Medication) List specific allergen and specific reaction (e.g. Amoxicillin causes hives and itching):
None ☐

_____

_____

_____

Name: _____ **Date of Birth:** _____

Medications: Prescription and over-the-counter taken on a CONSISTENT basis (e.g. Ranitidine 150 mg twice a day):
None ☐

	Medication	Dose	Directions/Time per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Past Surgical History: List surgery, date, hospital/location. (e.g. wisdom tooth extraction; July 1, 2011; Dr. Molar):
None ☐

_____

_____

_____

Hospitalizations: List reason, date and hospital/location:
None ☐

_____

_____

_____

Tobacco Use: Never Smoked ☐

Current *Every* Day Smoker: Yes, for _____ Years Packs per Day: _____

Current *Some* Day Smoker: Yes, for _____ Years Packs per Day/Week/Month: _____

Exposure to Secondhand Smoke: Yes, for _____ Years

Former Smoker: Yes, for _____ Years Date Quit: _____

Comment(s):

_____

_____

If answered yes to Tobacco Use or Exposure, please check all that apply:

Cigarettes: ☐ Chew: ☐ Cigars: ☐
Pipe: ☐ Snuff: ☐

Name: _____ **Date of Birth:** _____

Alcohol Use: No ☐
Yes ☐ Type: _____ Drinks per week: _____
Comment(s):

_____

_____

Illicit Drug Use: No ☐
Yes ☐ Type: _____ Times per week: _____
Comment(s):

_____

_____

Sexual Activity:
Partners: Male(s) ☐ Female(s) ☐ Not Currently: Yes ☐ No ☐

Birth Control or Other Contraception: _____
Comment(s):

_____

_____

Are you currently, or have you ever been, in a relationship where you were physically hurt, threatened, pressured to have sexual contact or made to feel afraid?

Currently: Yes ☐ No ☐ In the Past: Yes ☐ No ☐

Pregnancy History:
N/A ☐

Currently Pregnant: Yes ☐ No ☐

Total # of Pregnancies: _____ Total # of Living Children: _____

Full-term Births: _____

Premature (under 37 weeks): _____ Ectopic: _____ Miscarriage: _____ Abortion: _____ Stillborn: _____

Activities of Daily Living

Military Service:	No ☐ Yes ☐	Special Diet:	No ☐ Yes ☐
Blood Transfusion:	No ☐ Yes ☐	Back Care:	No ☐ Yes ☐
Caffeine Concern:	No ☐ Yes ☐	Exercise:	No ☐ Yes ☐
Use per week: _____		Type: _____	
Occupational Exposure:	No ☐ Yes ☐	Times per week: _____	
Hobby Hazards:	No ☐ Yes ☐	Bike Helmet:	No ☐ Yes ☐
Sleep Concern:	No ☐ Yes ☐	Seatbelt:	No ☐ Yes ☐
Weight Concern:	No ☐ Yes ☐	Self-Exams (Breast, Testicular):	No ☐ Yes ☐

Name: _____ **Date of Birth:** _____

Tests:

Date of last Mammogram: _____ Where performed? _____ or N/A ☐

Date of last Colonoscopy: _____ Where performed? _____ or N/A ☐

Date of last Pap Smear: _____ Where performed? _____ or N/A ☐

Date of last Bone Density: _____ Where performed? _____ or N/A ☐

Personal Current/Past Medical History

		Year Diagnosed	Comment
Breast Cancer	No ☐ Yes ☐		
Ovarian Cancer	No ☐ Yes ☐		
Uterine Cancer	No ☐ Yes ☐		
Colon Cancer	No ☐ Yes ☐		
Prostate Cancer	No ☐ Yes ☐		
Other Cancer	No ☐ Yes ☐		Type(s):
High Blood Pressure	No ☐ Yes ☐		
Stroke/CVA	No ☐ Yes ☐		
Heart Disease/Attack	No ☐ Yes ☐		
High Cholesterol	No ☐ Yes ☐		
Diabetes	No ☐ Yes ☐		List Type 1 or 2:
Thyroid Disease	No ☐ Yes ☐		
Alcohol Dependency	No ☐ Yes ☐		
Drug Dependency	No ☐ Yes ☐		
Depression	No ☐ Yes ☐		
Anxiety	No ☐ Yes ☐		
Other Psychiatric Concerns	No ☐ Yes ☐		
Memory Concerns	No ☐ Yes ☐		
Allergies	No ☐ Yes ☐		
Asthma	No ☐ Yes ☐		
Osteoporosis	No ☐ Yes ☐		
Sickle Cell Disease	No ☐ Yes ☐		
Autoimmune Disease	No ☐ Yes ☐		Type:
Aneurysm	No ☐ Yes ☐		Location:

Other _____

_____

Name: _____ **Date of Birth:** _____

Are you adopted?

No ☐ Please check the box associated with family members who currently have or have had the following medical conditions.

Yes ☐ If history known of any blood relatives, please check the appropriate boxes below.

Be sure to complete front and back of this form.

Relationship:	**Name:**	**STATUS:** Alive Deceased (Please circle)	Hypertension	Coronary/Heart	Aneurysm	Stroke/CVA	Cholesterol Disorder	Diabetes Mellitus	Thyroid Disease	Allergies/Asthma	Immunologic Disorder	Autoimmune Disease	Cancer Breast	Cancer Ovarian	Cancer Uterine	Cancer Colon	Cancer Prostate	Cancer Other	Gastrointestinal Disease	Kidney Disease
Father		A / D																		
Mother		A / D																		
Son(s):		A / D																		
		A / D																		
		A / D																		
Daughter(s):		A / D																		
		A / D																		
		A / D																		
Sister(s):		A / D																		
		A / D																		
		A / D																		
Brother(s):		A / D																		
		A / D																		
		A / D																		
Mom's Mother (Maternal Grandmother)		A / D																		
Dad's Mother (Paternal Grandmother)		A / D																		
Mom's Father (Maternal Grandfather)		A / D																		
Dad's Father (Paternal Grandfather)		A / D																		
Mom's Sister(s) (Maternal Aunt)		A / D																		
Dad's Sister(s) (Paternal Aunt)		A / D																		
Mom's Brother(s) (Maternal Uncle)		A / D																		
Dad's Brother(s) (Paternal Uncle)		A / D																		
Other		A / D																		

Name: _____ **Date of Birth:** _____

Relationship:	Name:	Strabismus / Lazy Eye	Deafness	Anemia	Bleeding Disorder	Sickle Cell Disease	Neurological Disorder	ADD/ADHD	Learning Disability	Depression	Anxiety	Psych-Other	Dementia	Alcohol/Drug	Osteoporosis	Other	Other	Unknown-FHx
Father																		
Mother																		
Son(s):																		
Daughter(s):																		
Sister(s):																		
Brother(s):																		
Mom's Mother (Maternal Grandmother)																		
Dad's Mother (Paternal Grandmother)																		
Mom's Father (Maternal Grandfather)																		
Dad's Father (Paternal Grandfather)																		
Mom's Sister(s) (Maternal Aunt)																		
Dad's Sister(s) (Paternal Aunt)																		
Mom's Brother(s) (Maternal Uncle)																		
Dad's Brother(s) (Paternal Uncle)																		
Other																		