WESTERN WAKE WELLNESS, PLLC
ADULT HEALTH HISTORY

401 KEISLER DRIVE
SUITE 101
CARY NC 27518
919-378-1492
www.WesternWakeWellness.com

Patient Name: ______________________________________ **Birth Date**: __________ **Age**: _____ **Today's Date:** _______
Name I would like to be called: ___________________________ My pharmacy is: ___________________________________

PAST MEDICAL HISTORY Please check Past (P) or Current (C) Medical problems.				**SURGICAL HISTORY**	**Year?**
□P □C	Diabetes	□P □C	Thyroid or endocrine problems	□ Heart surgery	
□P □C	Hypertension	□P □C	Kidney Disease	□ Carotid artery surgery	
□P □C	High cholesterol	□P □C	Liver Disease	□ Vascular surgery/stent	
□P □C	Heart attack or angina	□P □C	Bowel/Digestive problem	□ Abdominal aneurysm repair	
□P □C	Palpitations or arrhythmia	□P □C	Gastroesophageal reflux	□ Tonsillectomy	
□P □C	Atrial fibrillation	□P □C	Stomach ulcer	□ Wisdom teeth removed	
□P □C	Congestive heart failure	□P □C	Anemia or Bleeding disorder	□ Cholecystectomy (Gallbladder)	
□P □C	Heart murmur	□P □C	Blood transfusion	□ Appendectomy	
□P □C	Emphysema, chronic bronchitis	□P □C	Headaches	□ Hysterectomy	
□P □C	Asthma	□P □C	Stroke	□ Cesarean section	
□P □C	Pneumonia	□P □C	Seizures or epilepsy	□ D&C	
□P □C	Nasal allergies	□P □C	Sleep problems; snoring	□ Breast surgery	
□P □C	Problems with eyes or vision	□P □C	Obesity, overweight	□ Prostate cancer surgery	
□P □C	Problems with ears or hearing	□P □C	Skin problems (acne, eczema)	□ Hernia repair	
□P □C	Osteoporosis or osteopenia	□P □C	Frequent Urinary tract infection	□ Hemorrhoidectomy	
□P □C	Arthritis	□P □C	Breast problem	□ Cataract surgery □Right □Left	
□P □C	Depression	□P □C	Problem with menstrual cycle	□ LASIK	
□P □C	Anxiety	□P □C	Prostate problem	□ Spine surgery □ Neck □ Back	
□P □C	Mental illness	□P □C	Sexually transmitted infection	□ Joint replacement □ Knee □ Hip	
□P □C	Addiction issues	□P □C	Fracture or broken bones	□ Shoulder □Right □Left	
□P □C	Cancer (type):	□P □C	Other:	□ Other:	

GYNECOLOGIC HISTORY **Using birth control** □ No □ Yes What type? **Menopause** □ Yes □ No Age?

Menstrual flow □ Regular □ Irregular □ Pain/cramps **1st day of last period:** **Days of flow:** **length of cycle:**

# of Pregnancies: # of Miscarriages: # of Full-term deliveries: # of Pre-term deliveries:
Did you have diabetes during any of your pregnancies? □ No □ Yes

SOCIAL HISTORY Please check all that apply

Sex at birth: □ Male □ Female **Gender**: □ Male □ Female □ Genderqueer or not exclusively male nor female
My pronouns are: □ She/hers □ He/his □ They/their **Do you identify as transgender?** □ Yes □ No □ Don't know

Marital Status: □ Single □ Married □ Domestic Partnership □ Divorced □ Widowed
I identify as: □ Straight, Heterosexual □ Gay, Lesbian, Homosexual □ Bisexual □ Something Else □ Don't know

Occupation: Concerns: □ Stress □ Hazardous substances □ Heavy lifting
Tobacco Use: □ Never □ Secondhand smoke □ Quit (when?): □ Current Smoker: # Packs per day, How many years?
Alcohol Use: □ No □ Yes How many per month? Illicit Drug Use: □ No □ Past □ Current
Caffeine Use: □ No □ Yes □ Coffee □ Soda □ Tea □ Diet pills or supplements How many per day?
How many people live in your household? **Who lives with you?** □ Spouse □ Children □ Parents □ Other:
How often do you exercise? □ None □ 1-2x weekly □ 3-5x weekly □ Every day Doing what:
Do you have children? □ No □ Yes How many? **Do you have a Healthcare POA or Living Will?** □ No □ Yes

HEALTH MAINTENANCE & PREVENTION		Date			Date
Tetanus vaccine/TDaP	□ Yes □ No		Pap smear/pelvic exam	□ Yes □ No	
Pneumonia vaccine	□ Yes □ No		Mammogram	□ Yes □ No	
Influenza vaccine	□ Yes □ No		Bone density	□ Yes □ No	
Shingles vaccine	□ Yes □ No		Colonoscopy	□ Yes □ No	
Hepatitis vaccine □ A □ B □ Both	□ Yes □ No		Prostate exam & PSA blood test	□ Yes □ No	
Gardasil (HPV) vaccine	□ Yes □ No		Chest X-ray	□ Yes □ No	

FAMILY HISTORY		Are there any known genetic disorders in your family? □ Yes □ No	
Relationship	**Living**	**Age**	**Major Medical Problems, or Cause of Death**
Father	□ Yes □ No		
Mother	□ Yes □ No		
Paternal grandfather	□ Yes □ No		
Paternal grandmother	□ Yes □ No		
Maternal grandfather	□ Yes □ No		
Maternal grandmother	□ Yes □ No		
Siblings	□ Yes □ No		
Children	□ Yes □ No		

Has anyone in your family ever been diagnosed with any of the following conditions:

□ Diabetes	□ Thyroid Disease	□ Depression	□ Obesity	□ Breast Cancer
□ Hypertension	□ Pituitary Disease	□ Anxiety	□ Osteoporosis	□ Ovarian Cancer
□ Heart Attack	□ Crohn's Disease/Colitis	□ Mental Illness	□ Arthritis	□ Prostate Cancer
□ Stroke	□ Celiac Disease	□ Drug or Alcohol Abuse	□ Blood clots	□ Colon Cancer
□ Thalassemia	□ Asthma or allergies	□ Liver or Kidney disease	□ Bleeding disorder	□ Other Cancer:________
□ Sickle Cell Anemia	□ Cataract or glaucoma	□ Dementia/Alzheimers	□ Epilepsy/seizures	□ Other Cancer:________

Please list any allergies to medication or foods:	**Reaction:**

MEDICATIONS Please list all prescription medications, over the counter, herbal or natural supplements, inhalers, nasal sprays or creams

Name	Dose	Frequency	Name	Dose	Frequency

HOSPITAL ADMISSIONS (excluding pregnancy)

Date	Which hospital	Reason for Admission

SPECIALTY PROVIDERS To help us coordinate your care, please list any medical providers you see outside of this practice

□ Cardiology	□ Dermatology	□ ENT/Otolaryngology	□ Infectious Disease
□ Pulmonology	□ Nephrology	□ Allergy/Immunology	□ Podiatrist
□ OB/Gynecology	□ Gastroenterology	□ Orthopedics	□ Ophthalmology/Optometry
□ Urology	□ Neurology	□ Rheumatology	□ Psychiatrist/Psychologist
□ Endocrinology	□ Pain Specialist	□ Hematology/Oncology	□ Surgeon

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare? □ Yes □ No

Please use this space to share anything else that we need to know to best care for you.