KAISER PERMANENTE

Kaiser on the Job

Wellness Exam Instructions

The Wellness Examination focuses on your medical history, your family history, as well as doing an examination and lab work. We combine this information to obtain an overall view of your health and focus on areas of risk. Please fill out the first three pages of this form.

Imprint area

Wellness Exam - Adult

Name_____ Male☐ Female☐ Date of Birth_____

Home Address_____

Home Phone_____Cell_____ Work Phone_____

Occupation_____Spouse's name and Occupation_____

Social Security #_____Employer_____

Please answer all questions on the following three pages. Date_____
Write "unknown" or "NA" instead of leaving blanks.

Part 1 — Personal Health

Have you had any of the following?	YES	NO
Asthma	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Seizures (epilepsy)	☐	☐
High Blood Pressure	☐	☐
Glaucoma	☐	☐
Unusually severe depression/anxiety	☐	☐
Positive TB (tuberculosis) skin test	☐	☐
Radiation Treatment to any part of body	☐	☐
DES exposure (mother received hormones When pregnant with you)	☐	☐

Other chronic Medical Problems_____
_____
_____

Immunizations:
Date of last tetanus_____
If over 65, ever had pneumonia vaccine_____
Date Hepatitis B series completed_____
Date Hepatitis A series completed_____

Last **sigmoidoscopy**/colonoscopy_____

Women only:
Date of last Pap smear_____
Have Pap smears been normal_____
Date of last Mammogram_____
Have your mammograms been normal_____
Date of last bone density_____

Medications that you take regularly:

Name	Dosage	Why do you take it?

Medication allergies:

Name	Reaction	Year

Major Operations and Hospitalizations: None ☐

	Year	Specify Illness or Type of Surgery	Name of Hospital
A			
B			
C			
D			

Part II—Family Health

Has any family member had:				**Who?** (Specify relationship and if deceased, age at death)
Diabetes	☐Yes	☐No	☐Don't Know	
High Blood Pressure	☐Yes	☐No	☐Don't Know	
Heart Attack	☐Yes	☐No	☐Don't Know	
Stroke	☐Yes	☐No	☐Don't Know	
Breast Cancer	☐Yes	☐No	☐Don't Know	
Colon or Rectal Cancer	☐Yes	☐No	☐Don't Know	
Alcoholism/Addiction	☐Yes	☐No	☐Don't Know	
Suicide	☐Yes	☐No	☐Don't Know	

Name any additional health related conditions that run in your family: _____

Part III—Social & Lifestyle

Martial Status:

☐ Married ☐ Divorced ☐ Single ☐Widow ☐Widower ☐Separated

Who lives at home with you? (Such as spouse, sons, daughters, father-in-law, etc.): _____

Current method of birth control: _____ N/A ☐

Have you had more than 1 sexual partner in the past 12 months? Yes ☐ No☐

Are you concerned about your AIDS risk? If yes, explain: _____ Yes ☐ No☐

Sources of Tension and Worry:

☐ Job ☐ Marriage ☐Alcohol/Addic. ☐Children ☐Finances ☐Co-workers

☐ Drugs ☐Religion ☐Relatives ☐Other: _____

Check the Answer Most Appropriate for the Following Areas:

Tobacco

☐ Have never smoked.

☐ Smoke cigarettes. (Number of packs/day _____ Number of years _____)

☐ Smoke cigar or pipe. How much? _____

☐ Quit smoking. When? _____ What did you smoke? _____
How much did you smoke? (Number of packs/day _____ Number of years _____)
Do you use smokeless tobacco? Yes ☐ No ☐

Alcohol (One drink equals 1 shot of liquor, 1 glass of wine or 1 can of beer):

☐Four or more drinks/day ☐1-3 drinks/day ☐Less than 5 drinks/week ☐None

Number of alcohol free days per week:_____

Caffeine

☐Coffee ☐Tea ☐Cola Total number of cups/glasses/bottles per day: _____

Exercise

What do you do for exercise?_____
#days/week_____#minutes/day_____

Nutrition

servings/day fruits or vegetables?_____# servings/day whole grains_____
Do you eat breakfast regularly?_____#meals eaten out/week_____
Describe any special diet_____

Review of Systems

Please list and explain any current problems.

1. How would you describe your health? Good☐ Fair☐ Poor☐
   Why?_____

	Yes	No
2. In the past 6 months, have you lost more than 10lbs. without trying? Comment_____	☐	☐
3. Have you noticed any major changes in your skin (moles, etc.) recently? Describe_____	☐	☐
4. Do you have poor hearing or other ear problems? Describe_____	☐	☐
5. Do you have a persistent cough or hoarse voice? Describe_____	☐	☐
6. Do you have shortness of breath? Describe_____	☐	☐
7. Do you get chest pain when you are active? Describe_____	☐	☐
8. Have you ever been told you have a heart murmur? Explain_____	☐	☐
9. Do you frequently have heartburn or stomach pain? What do you do for it?_____	☐	☐
10. Do you have blood in your bowel movements or a change in character of your bowel movements? Describe_____ _____	☐	☐
11. Do you have significant joint or bone problems, or back/neck pain that interferes with your work or lifestyle? Explain_____ _____	☐	☐
12. Do you have any breast lumps? Describe_____	☐	☐
13. Do you have abnormal vaginal bleeding (including bleeding after menopause?) _____	☐	☐
14. Are there sexual problems you wish to discuss?	☐	☐
15. Do you have any other questions or problems you wish to discuss? Explain_____	☐	☐