*In order to save your responses, this form must be downloaded **before** filling. See return instructions at end of form.*

Elevate Health Adult Annual Exam Medical Review

Today's date: ______

Name: ______________________________________ Pronouns:___________ DOB: _________

General Medical History and Review

Any major illness, injury, surgery or hospitalizations since your last visit? ○Yes ○No

If yes, please describe:____

Any new, changed, dark, large, itching, bleeding or irregular moles? ○Yes ○No

Any recurring, distressing, intrusive, irrational or unreasonable thoughts or behaviors? ○Yes ○No

Any new social stressors?

□ Marriage	□ Job	□ Family	□ Financial
□ Divorce	□ Deaths	□ Relationships	□ Legal
□ Separation	□ Housing	□ Illness	

Any current or previous sexual or physical abuse that you would like us to be aware of? ○Yes ○No

If yes, would you like to discuss this today or in the future? ○Yes ○No

When was your most recent eye exam? ___________________

When was your most recent dental exam? ________________

Any symptoms of heavy snoring? ○Yes ○No

Do you often breathe through your mouth? ○Yes ○No ○Don't know

Are you interested in being up to date with recommended vaccines? ○Yes ○No

Family Planning and Sexual History

Are you currently sexually active (in the past 3 months)? ○Yes ○No

What form(s) of birth control do you use?

☐ n/a	☐ IUD	☐ Implanon
☐ Condom	☐ Vaginal Ring	☐ Rhythm method
☐ Pill	☐ Depo shot	☐ Natural family planning

Do you sometimes have sex without protection from sexually transmitted infections? ○Yes ○No

Do you sometimes have sex without a birth control method? ○Yes ○No ○ n/a

Have you had a new sexual partner in the last 3 months? ○Yes ○No

Are you concerned you or your partner might have an STI? ○Yes ○No

Would you like to have blood and urine screening tests for STI's? ○Yes ○No

Do you have questions or concerns about sex, libido or birth control? ○Yes ○No

If yes, please specify: ____

Do you have any updates, questions or concerns about gender identity? ○Yes ○No

Health Habits and Health Maintenance Review

How many ounces of water do you drink daily? ___

How many hours of sleep do you get nightly?___

Formal exercise, hours per week:

Cardio/Aerobic___	Balance ___
Strength/Resistance ___	Sports/Leisure ___
Flexibility/Stretching ___	

Do you smoke, vape or chew tobacco? ○Yes ○No If yes, how much? ________

Are you regularly exposed to cigarette smoke where you live or work? ○Yes ○No

Caffeine, ounces of caffeinated beverages per day: ___

Alcohol, drinks per week: ___

Do you think you need to cut back on your drinking? ○Yes ○No

Recreational drugs, type and frequency: _______________________________________

Do you have any concerns about addictive behavior, including gambling, eating, drugs, sex, porn, gaming, electronic devices? ○Yes ○No If yes, please specify _______________________________

Seatbelt worn:

☐ Always ☐ Occasionally ☐ Never ☐ n/a

Bike helmet worn:

☐ Always ☐ Occasionally ☐ Never ☐ n/a

If you have firearms in your home, are they locked? ○Yes ○No ○ n/a

Any exposure in your home or workplace to:

☐ Chemicals ☐ Mold ☐ Radiation ☐ Noise ☐ Hazards

Genitourinary Health

Any unusual genital:

☐ Discharge ☐ Itching ☐ Odor ☐ Burning

Any of these symptoms?

☐ Discharge from penis
☐ Ejaculation problem
☐ Genital pain/discomfort
☐ Erectile complaints
☐ Lumps in testicles
☐ Testicular pain
☐ Lumps in chest
☐ Infection in groin
☐ Urinary urgency
☐ Urinary frequency
☐ Blood in urine
☐ Blood in semen
☐ Pain with urination
☐ Pelvic pain/discomfort
☐ Pain with sex
☐ Leaky urine

Any:

☐ Recurrent vaginal yeast infections ☐ Recurrent urinary tract infections

Do you do testicular self-exams? ○Yes ○No ○n/a

Any:

☐ Breast lumps
☐ Breast biopsies
☐ Breast cancer
☐ Abnormal mammograms
☐ Nipple discharge
☐ Breast pain
☐ Nipple pain

Do you get regular mammograms? ○Yes ○No ○n/a

Are you currently breastfeeding? ○Yes ○No ○n/a

Menstrual Health:

☐ Heavy flow
☐ Cramps
☐ Spotting after sex
☐ Irregular periods
☐ Missed periods
☐ Bad PMS
☐ Spotting between periods

Any symptoms of peri/menopause?

☐ Leaky urine
☐ Hot flashes
☐ Night sweats
☐ Vaginal dryness
☐ Chronic sleep issues
☐ Mood problems
☐ Vaginal bleeding/spotting
☐ Memory concerns

If you are menstruating, when was your most recent period? _______________

Thank you for taking the time to thoughtfully answer these questions.
This information is extremely helpful in optimizing your care.

Please save your changes to this form, and email to: medassist@elevatehealthpdx.com

i if you would like to erase your responses and start over.