*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

**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

*Review continues on next page.*

**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

**Genitourinary Health**

Any unusual genital:

☐ Discharge ☐ Itching ☐ Odor ☐ Burning

Any of these symptoms?

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

Any:

☐ Recurrent vaginal yeast infections ☐ Recurrent urinary tract infections

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

Any:

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

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

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

Menstrual Health:

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

Any symptoms of peri/menopause?

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

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 e-mail to: medassist@elevatehealthpdx.com*
*To delete all answers, click the button below. This cannot be reversed.*

CLEAR ALL