David L. Anders, M.D., P.C.• Internal Medicine & Geriatrics • 101 McWilliams Drive • Peachtree City, GA 30269 • 770-487-0808

Wellness & Medical Information Update 20200706

Name____ Date______________________

Please answer the following questions to the best of your ability. If you find questions which you are uncertain about or do not understand, leave them unanswered.

Review of Past Medical History/ Family History/ Current Medications

If you have an existing electronic medical record in our practice, you will receive a printout of your past medical history, family medical history and list of medications. Please confirm this information or request a worksheet to complete.

Screening & Prevention

List the last date (if ever) you had the following tests or immunizations:

Procedure	Date (Year)	Procedure	Date (Year)
Colonoscopy	__________	Mammogram	__________
Flu vaccination	__________	Blood cholesterol	__________
Tdap (tetanus/diphtheria)	__________	Blood glucose (sugar)	__________
Tetanus vaccination	__________	PAP smear	__________
Prevnar-13 (pneumonia)	__________	Chest X-ray	__________
Pneumonia vax-23	__________	TB skin test	__________
Shingrix (shingles vax)	__________	Prostate (PSA) blood test	__________
Bone Density (DEXA)	__________		

Lifestyle

Please answer the following questions pertaining to your social history, habits, and lifestyle:

In an average week, **how many** of the following alcoholic beverages will you drink?

___ None/NA
___ 12 ounce beer
___ 4 ounce wine
___ 1 ounce liquor

What is your marital status?

___ single
___ married
___ separated
___ divorced
___ widowed

If you are/were employed, what is/was your occupation? ______________________ Are you retired? ____Yes ____No

Do you have any reason to feel you may have been exposed to the AIDS virus? ____Yes ____No

Do you regularly wear a seat belt? ____Yes ____No

On a scale of "1 (low) to 10", how healthy is your diet? ______
List any foods or types of foods you attempt to avoid in your regular daily meals:

____.

Name____ Date________________________

For the tobacco/nicotine products listed below, please indicate whether you have ever been a regular user of each product, and the year started (and quit, if applicable) and the daily amount used:

Product	Never used	Former user	Current user	Year started	Year Quit	Daily amount used
Cigarettes	________	________	________	_________	_________	______________
Pipe	________	________	________	_________	_________	______________
Cigars	________	________	________	_________	_________	______________
Smokeless	________	________	________	_________	_________	______________
Vaping	________	________	________	_________	_________	______________

If you currently use a tobacco/nicotine product, are you interested in quitting? ____Yes ____No

Do you wear glasses or contact lenses? ____Yes ____No

Do you wear dentures? ____Yes ____No

When was your last eye exam? ____________________________

When was your last dental exam? ____________________________

On a scale of "1 (low) to 10", how much stress are you under? ______

Do you manage this level of stress well? ____Yes ____No

Describe any routine exercise activity, including the type of activity, frequency and duration or distance:

____

End of Life Planning

Have you appointed a Durable Power of Attorney for Health Care? ____No ____Yes

Physician signature after notation by the physician supplementing and confirming this information as indicated above and/or recorded in the electronic medical record document created on this date: