Summit Healthcare at Bison Ranch
2352 Quarter Horse Trail / Overgaard
Phone: 928-535-3616

Wellness (Ages 19 and up)

Date: _____ Born: Male / Female

Name: _____

Date of Birth: _____

Do you have an advanced directive, such as a living will? Yes / No

What Pharmacy do you prefer?_____

Do you exercise regularly? Yes / No

- How many days a week do you exercise?_____
- How many minutes a week do you exercise? _____
- What type of exercise do you perform? (circle all applicable) Cardio / Strength training

Diet

- How would you describe your diet? (circle all applicable)
  Healthy / Junk food / Low fat / Low sodium
- Are you on a specialty diet? Yes / No Name: (i.e. keto) _____

Alcohol

- Do you drink alcohol? Yes / No
- How much do you drink? _____drinks every (circle one) day / week / month
- What do you drink? Wine / Beer / Hard liquor

Tobacco Use

- Do you use any tobacco products? Yes / No / Former user
  - What type of tobacco do you use? (circle all applicable) cigarettes / cigars / pipe / vape chew
  - When did you begin using tobacco? _____(Year if known)
  - How much tobacco do you use? _____(circle one) day / week
  - When did you quit?_____

Caffeine Use

- Do you drink any type of caffeine? Yes / No
  - What type of caffeine do you drink? (circle all applicable) Coffee / Tea / Soda / Energy drink
  - How many cups / cans a day?_____

HIV Risk

- Are you sexually active with: (circle all applicable) Men / Women / Not sexually active
- Have you had multiple sex partners? Yes / No
- Have you ever used recreational IV (intravenous) drugs? Yes / No

For Women Only

- Are you menopausal? Yes / No
- Have you had a hysterectomy? Yes /No Year: _____ Reason: _____
- Date of last menstrual period? _____
- Do you perform self-breast exams? Yes / No
- Are you experiencing any of the following? (circle all applicable)

Breast lump / Nipple discharge / Breast skin changes / Breast tenderness / Hot flashes / Insomnia /
Mood swings / Vaginal discharge / Pain with intercourse / Skin changes or Rashes

Please circle one answer for each of the following questions….

	Not at All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?	0	1	2	3

Screenings: Have you had any of the following screening tests? (Please list date of most recent test)

- Colonoscopy Yes / No Date: _____
- ColoGuard Yes / No Date: _____
- EGD Yes / No Date: _____
- Mammogram Yes / No Date: _____
- Dexa Scan Yes / No Date: _____
- Abdominal Aortic Ultrasound Yes / No Date: _____
- Low-Dose CT of Chest (lung) Yes / No Date: _____
- Pap Smear Yes / No Date: _____
- Cholesterol Screening Yes / No Date: _____
- Diabetes Screening Yes / No Date: _____
  - Diabetic Eye Exam Yes / No Date: _____
  - Diabetic Foot Exam Yes / No Date: _____

Immunizations: Have you had any of the following immunizations?

- Pneumonia Yes / No Date:_____
- Tetanus Yes / No Date: _____
- Shingles Yes / No Date:_____
- Flu Yes / No Date:_____
- Covid Yes / No Date:_____

Surgery	Date	Location

☐ No new surgical history since last annual

Medical Condition	Date Diagnosed	Provider Treating Condition

☐ No new medical history since last annual

Family History	Date	Relation

☐ No new family history since last annual

Do you have any known Allergies? Yes / No
Please list the medication and reaction: _____

Medication list (Please list all medications you take including over-the-counter medications and those Prescribed by a different office)

☐ No new medications since last visit

Medication	Dose	Frequency (i.e. twice daily)	Name of prescribing Provider	Do you need a refill today? Yes / No

Please list any specialists involved in your care: _____

FOR PATIENTS 65 OR OLDER PLEASE TURN PAGE AND FILL OUT PAGE 4

Patients 65 years old and older, please answer the following additional questions.

Are you unable to perform any of the following activities? (circle all applicable)

- Go Shopping
- Use the Telephone
- Housekeeping
- Laundry
- Bathing or showering
- Dressing yourself
- Cooking for yourself
- Use the toilet by yourself
- Manage your own medications
- Manage your finances
- Operate a vehicle

In the last month have you felt any of the following? (circle all applicable)

- Depression
- Stress
- Anger
- Loneliness
- Pain
- Fatigue

Have you fallen within the last year? Yes / No

- How many times? _____
- Did you have to undergo medical treatment following the fall? Yes / No

Do you feel you are having problems with your hearing? Yes / No

Do you feel you are having problems with your vision? Yes / No

Do you feel you are having problems with your oral health? Yes / No

Do you feel you are having problems with your memory? Yes / No

Are you satisfied with your sex health? Yes / No