FOR OFFICE USE ONLY: H_____W_____B_____P_____T_____O2 _____

MOSAIC
COMPREHENSIVE CARE

Annual Update Form

Legal name: _____ Preferred name (if different): _____

Gender identity: ☐ Female ☐ Transgender woman ☐ Transgender man ☐ Genderqueer/gender non-binary ☐ Male ☐ Decline to state

What sex were you assigned at birth?: ☐ Female ☐ Male ☐ Decline to state

Preferred pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other_____

What is the reason for your visit today?: ☐ annual exam ☐ Other_____

Primary Care Provider: _____ Specialists: _____

List all medications:

	Refill needed?		Refill needed?
1. _____	☐	5. _____	☐
2. _____	☐	6. _____	☐
3. _____	☐	7. _____	☐
4. _____	☐	8. _____	☐

List all current supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Preferred Pharmacy: Name_____ Address: _____

List any drug allergies (including type of reaction): ☐ None _____

List dates of immunizations:

Hepatitis A _____ Flu shot _____ Tetanus/Tdap _____ HPV _____

Hepatitis B _____ Pneumonia _____ Shingles_____

Social History:

Occupation:_____ Place of employment:_____

Have you used tobacco products: ☐ Yes ☐ No

How many per day:_____

Number of years:_____Date quit:_____

Do you use drugs? ☐ Yes ☐ No

What type of drugs?_____

Do you drink alcohol? ☐ Yes ☐ No Type:_____

How many drinks per week?_____

History of alcohol abuse? ☐ Yes ☐ No

Have you ever felt the need to cut down? ☐ Yes ☐ No

Have you ever felt guilty about drinking? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Married ☐ Domestic partner ☐ Separated ☐ Divorced ☐ Widowed

Who do you live with?_____

If you have children, what are their ages?_____

Do you exercise? What type and how often?_____

Nutrition: Is there anything unique about your diet, including foods that you avoid:_____

Do you have an advanced directive? ☐ Yes ☐ No

Do you have a Health care power of attorney? ☐ Yes ☐ No Name: _____

New medical problems, surgeries, and injuries since last visit: _____

_____

Preventive Care: Please list dates of screening tests if applicable.

Last pap smear: _____ ☐ Normal ☐ Abnormal _____

Last mammogram: _____ History of abnormal mammogram? ☐ Yes ☐ No Results:_____

Bone density test: _____ Results: ☐ Normal ☐ Osteopenia ☐ Osteoporosis

Colonoscopy :_____ Results: ☐ Normal ☐ Polyps ☐ Abnormal _____

Family History:

List any changes in your family medical history since your last visit:_____

_____

Gynecologic history (if applicable):

Age when period started:_____ Last menstrual period:_____ ☐ Postmenopausal

Number of days between the first day of your period and the first day of your next period: _____

Regular periods: ☐ Yes ☐ No Any recent changes in your periods?_____

Number of pads/tampons used on heaviest day of flow:___ Menstrual cramps ☐ none ☐ mild ☐ mod ☐ severe

Pregnancy history (if applicable):

Total number of pregnancies:___ Number of living children:____ Number of ectopic pregnancies:___

Number of full-term births: ____ Number of adopted children:____ Number of abortions:____

Number of preterm births:____ Number of miscarriages:_____

Sexual/relationship History:

Do you think of yourself as: ☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Queer ☐ Don't know ☐ Decline to answer

What do you use for birth control (if applicable): ☐ birth control pills ☐ condoms ☐ IUD ☐ Nexplanon/Implanon ☐ Nuvaring ☐ Depo-Provera ☐ Diaphragm ☐ tubal ligation ☐ vasectomy

History of sexually transmitted infections? ☐ Yes ☐ No Explain:_____

Do you wish to be screened for sexually transmitted infections? ☐ Yes ☐ No

Have you been physically hurt by your partner or ex-partner? ☐ Yes ☐ No

Have you been emotionally abused by your partner or ex-partner? ☐ Yes ☐ No

Do you currently have any of the following symptoms? Please check all that apply.

General: ☐ Chills ☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight loss

Eye/Ear/Nose/Throat: ☐ Ear Drainage ☐ Ear Pain ☐ Eye Discharge ☐ Eye Pain ☐ Hearing Loss ☐ Nasal Congestion ☐ Nasal Drainage ☐ Sinus Pressure ☐ Sneezing ☐ Sore Throat ☐ Itchy Eyes ☐ Visual Changes

Respiratory: ☐ Cough ☐ Shortness of Breath ☐ Wheezing

Cardiovascular: ☐ Chest Pain ☐ Edema ☐ Palpitations

Gastrointestinal: ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Loss of Appetite ☐ Nausea ☐ Vomiting

Genitourinary & Reproductive: ☐ Dysuria ☐ Blood in Urine ☐ Awakening at Night to Urinate ☐ Urinary Frequency ☐ Urinary Incontinence ☐ Burning with Urination ☐ Lack of Periods ☐ Painful Periods ☐ Heavy Periods ☐ Irregular Periods ☐ Low Libido ☐ Pain with Sex ☐ Hot Flashes ☐ Vaginal Discharge ☐ Vaginal Dryness

Breast: ☐ Nipple Discharge ☐ Lumps ☐ Breast Pain

Dermatologic: ☐ Excessive Hair ☐ Hives ☐ Itching ☐ Changes in Moles ☐ Rash ☐ Skin Lesion

Neurological: ☐ Dizziness ☐ Numbness ☐ Weakness ☐ Gait Disturbance ☐ Headache ☐ Memory Loss ☐ Loss of Consciousness ☐ Seizures ☐ Tingling ☐ Tremors

Mental Health: ☐ Anxiety ☐ Depression ☐ Insomnia ☐ Suicidal Thoughts

Endocrine: ☐ Cold Intolerance ☐ Heat Intolerance ☐ Excessive Thirst

Musculoskeletal: ☐ Back Pain ☐ Joint Pain ☐ Joint Swelling ☐ Muscle Weakness ☐ Neck Pain ☐ Muscle Aches

Hematologic: ☐ Easy Bleeding ☐ Easy Bruising

Allergies: ☐ Contact Allergies ☐ Environmental Allergies ☐ Food Allergies ☐ Seasonal Allergies

Depression screening:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	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

Eating disorder screening:

Are you satisfied with your eating patterns? ☐ Yes ☐ No

Do you ever eat in secret? ☐ Yes ☐ No

Does your weight affect the way you feel about yourself? ☐ Yes ☐ No

Have any members of your family suffered with an eating disorder? ☐ Yes ☐ No

Do you currently suffer with or have you ever suffered in the past with an eating disorder? ☐ Yes ☐ No