



Wellness Exam / Intake Form
Dr. Todd Bergland, Glacier Medical Associates

Date of Appointment: _____
(updated by TAB, 04 May 2012)

*Please do your best to fill out everything on this form. It is important for me to know the following information, even if you feel like it does not apply to the reason you are coming in for care. I value your time and aim only to provide the best care possible. Our lab opens at 8 AM, M-F, **please come in fasting (nothing after midnight) at least one day prior to your appointment to have appropriate labs drawn.** Thanks and I look forward to our visit.*

-Dr. Bergland.

Name: _____ Sex: M or F Date of Birth: _____

Address: _____ Phone: _____

Today's Date: _____ Email Address: _____

1. MEDICAL PROBLEMS/ Diagnosis:

2. CURRENT MEDICATIONS: *(List all pharmaceutical medications and dosages that you are currently taking, as well as supplements and over the counter medications. If you do not have enough space, please use the back of this form to complete).*

_____ Refill _____ Refill
_____ Refill _____ Refill
_____ Refill _____ Refill
_____ Refill _____ Refill
_____ Refill _____ Refill

3. Do you take a daily **Aspirin** ? No Yes, 81 mg Yes, 325 mg

4. If you are female, do you take **1200 mg Calcium & 400 IU of Vitamin D** daily? No Yes

5. **ALLERGIES:** *Do you have any allergies to medication, foods, or other allergens in your environment?*

6. Surgeries and Dates:

7. Family History:

Please mark P (past) or C (current) for any of the following that your family members have had.

Condition	Mother	Father	Siblings	Aunt/Uncle	Grand-parent	Child
Alcoholism						
Anxiety/Depression						
Blood Clots						
Breast Cancer						
Colon Cancer						
Prostate Cancer						
Cancer, Other						
Diabetes						
Heart Disease						
High Blood Pressure						

8. Reproductive, Female:

Date of last DEXA (bone density) scan, and result: _____

Date of last Pap Exam: _____ Abnormal?: No Yes

If yes how was it treated? Biopsy Freezing Laser LEEP Acid Conization

How often do you examine your breasts? _____

Date of Last Mammogram: _____ Abnormal?: No Yes

Method of Birth Control? _____

Is there a possibility you are pregnant? No Yes

Are you Breast Feeding? No Yes

of Pregnancies: ____ Full Term Deliveries: ____ Pre-Term: ____ Miscarriages/Abortions: ____

9. Reproductive, Male:

After reading and considering the prostate cancer screening handout, would you like to be tested for prostate cancer? No Yes Please circle one or both: Rectal Exam and/or PSA

ADAM Questionnaire	No	Yes
1. Do you have a decrease in sex drive?		
2. Do you have a lack of energy?		
3. Do you have a decrease in strength and/or endurance ?		
4. Have you lost height?		
5. Have you noticed a decreased enjoyment of life?		
6. Are you sad and/ or grumpy?		
7. Are your erections less strong?		
8. Has it been more difficult to maintain your erection throughout sexual intercourse?		
9. Are you falling asleep after dinner?		
10. Has your work performance deteriorated recently?		

10. Health Habits	Yes	No	If Yes: how long, & how many days per week?
Do you exercise (at least 30 minutes of aerobic exercise, total, in a day)?			
Do you smoke tobacco or dip? Past or present use?			
If you use Tobacco, would you like to quit?			
Do you drink alcohol?			
If yes, have you ever felt you needed to cut down on drinking?			
If yes, have people annoyed you by criticizing your drinking?			
If yes, have you ever felt guilty about drinking?			
If yes, have you ever felt you needed a drink first thing in the morning?			
Have you had a Flu Shot?			Date: Where?
Have you had a HPV (human papilloma virus) Vaccine?			Date: Where?
Have you had a Pneumonia Vaccine?			Date: Where?
Have you had a Hepatitis B Vaccine?			Date: Where?
Have you had a Tetanus Vaccine?			Date: Where?
Have you had a Zoster (Shingles) Vaccine?			Date: Where?
Have you had a Complete Blood Count?			Date: Where?
Have you had your fasting Glucose checked?			Date: Where?
Have you had a Lipid Panel (Cholesterol)?			Date: Where?
Have you had a new sexual partner in the past 10 years?			
Do you have any reason to suspect you have a sexually transmitted disease?			
Do you want to be tested for sexually transmitted diseases?			
Have you had an Annual / Physical Exam ?			Date: Where?
Have you had a Colonoscopy or Flexible Sigmoidoscopy?			Date of last exam: Where? Findings:
Do you have any concerns for your safety at home?			
Do you have an advance directive (living will and/or durable power of attorney for healthcare)?			If yes, where is it located?

11. Review of Symptoms:

(Please place a check beside any of the following you have been bothered by in the past few months.)

- Feeling DOWN, DEPRESSED or HOPELESS?
- LITTLE INTEREST or PLEASURE in doing things?
- TROUBLE SLEEPING?
- Unexplained WEIGHT GAIN or LOSS?
- FEVERS, CHILLS, or NIGHT SWEATS?
- Frequent or periodic HEADACHES?
- LIGHTHEADEDNESS, DIZZINESS or PASSING OUT
- NUMBNESS, TINGLING, or WEAKNESS of the Extremities?
- Problems with your HEARING?
- RINGING in your EARS?
- Problems with your TEETH (cavities, broken teeth, etc)?
- HOARSENESS or other changes in your voice?
- LOSS OF VISION, DOUBLE VISION, or BLURRED VISION?
- CHEST PAIN or PRESSURE?
- IRREGULAR or RAPID HEART BEATS?
- SWELLING in your FEET, ANKLES, or HANDS?
- CHANGE in your EXERCISE TOLERANCE?
- SHORTNESS OF BREATH, COUGHING, or WHEEZING?
- ABDOMINAL PAIN?
- HEARTBURN?
- VOMITING or FEELING FULL earlier than usual?
- BLOODY or BLACK TARRY STOOLS?
- DIARRHEA or CONSTIPATION?
- BLOOD in your URINE or SEMEN?
- A LUMP or MASS on one of your TESTICLES?
- WAKING FREQUENTLY AT NIGHT TO URINATE?
- TROUBLE STARTING URINATION?
- SEXUALLY TRANSMITTED DISEASES?
- MUSCLE or JOINT PAINS?
- CHANGING MOLES or LESIONS?
- EXCESSIVE THIRST or URINATION?
- EASY BRUISING or EXCESSIVE BLEEDING?
- ENLARGED LYMPH NODES (swollen glands)?
- SEASONAL ALLERGY SYMPTOMS (Congestion, Itchy eyes, Sneezing)?
- Concerns about your SEXUAL FUNCTION ?
- Total

****If you are 65 years old or older and have Medicare, please complete the next page.****

If not, please stop here.

Thank you!

Supplement – Complete if you are 65 years old or above

12. Safety	Yes	No	If Yes, please give details.
Do you require assistance with any of the following: - using the phone? - transportation or shopping? - preparing meals? - housework or laundry? - medications? - managing money?			
Does your home have loose rugs?			
Does your home have any poorly lit areas?			
Would you like a referral for a hearing evaluation?			
Does your home have grab bars in the bathroom and handrails on the stairways?			

13. Please list all **other physicians** you currently see:

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