

## Definition of a Well-Care Visit

The focus of a well-care visit is preventive care. If tests or services beyond the scope of a well-care visit are provided, then additional charges may be incurred for those services. The choice to address both well care and medical issues is offered for the convenience of avoiding two visits. Although our office will assist you with your insurance processing, it is the patient's responsibility to understand their insurance benefits.

*Please remember that Medicare and DSHS\* do not cover well care visits.*

What is a Well-Care Visit?	
YES	NO
A review of your current health and medical history.	Treatment or consultation for a specific medical condition.
Counseling about ways to improve your health.	Any service not considered part of a well-care visit.
A physician exam tailored to your preventive care needs.	
Immunizations and screening tests, if needed. <i>(billed separately)</i>	

Your scheduled appointment day is for an Annual Exam which is a well-care visit. Each insurance company has different contracts regarding group and individual coverage for Well Exam benefits. We do not know your contract so we cannot tell you if your insurance company is going to cover the charge for a well exam. If tests or services beyond the scope of a well-care visit are provided, then you may incur additional charges.

- ❖ If you are uncertain of your coverage, please contact your insurance company regarding benefits.
- ❖ I fully understand and agree to pay Inter Island Medical Center for this service if my insurance company denies my claim.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\* DSHS *does* cover well-care visits for children age 18 and younger.

**Well-Woman Exam**

Patient's name: \_\_\_\_\_

Your age: \_\_\_\_\_ Occupation/hobbies: \_\_\_\_\_

When was your last period? \_\_\_\_\_

When was your last PAP test? 1 year ago 2 years ago >3 years ago

Were the results normal? Yes No Have you ever had an abnormal PAP? Yes No How often do you usually get your period? Every \_\_\_\_\_ days

Are your periods usually regular? Yes No

How many days do your periods usually last? \_\_\_\_\_ days

The blood flows is: Light Moderate Heavy

Do you have bleeding between periods? Yes No

Are you sexually active? Yes No

If yes, do you and your partner use birth control? Yes No

Method: \_\_\_\_\_

Pain during sex? Yes No

Have you ever been pregnant? Yes No

How many? Pregnancies? \_\_\_\_\_ to term \_\_\_\_\_ premature \_\_\_\_\_ abortions \_\_\_\_\_ living children

Have you ever had a sexually transmitted disease? Yes No . Have you ever been abused? Yes No

Do you feel safe? Yes No

Do you have hot flashes? Yes No

Are you on hormone replacement? Yes No Ever? \_\_\_\_\_

Do you perform self breast-exams? Yes No How often? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

Have you ever had a colonoscopy? Yes No Have you had a DEXA scan? Yes No Have you had a pneumonia vaccine? Yes No Date of last Tetanus? \_\_\_\_\_

Life style:

Do you smoke? Yes No Ever?(when/how much?) \_\_\_\_\_

Do you drink alcohol? Never 1-2/month 1-2/week 1/day 2/day 3/day more

Do you use street drugs? Yes No If yes, what type/how often? \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Past medical history

Circle if YOU have ever had any of the following:

- |                         |                  |                 |
|-------------------------|------------------|-----------------|
| Depression              | Diabetes         | Seizures        |
| Liver disease/Hepatitis | Cancer           | Blood disorder  |
| Lung disease/asthma     | Bowel disease    | Substance abuse |
| Eye problems            | Osteoporosis     | Hypertension    |
| Heart disease           | Eczema/Allergies | Thyroid disease |

Other \_\_\_\_\_

List any surgeries: \_\_\_\_\_

List any major illnesses: \_\_\_\_\_

Family History

Circle if any of your relatives (mother, father, siblings, grandparents) experienced any of the following?

- |                            |                             |
|----------------------------|-----------------------------|
| Depression/suicide         | Alcohol/drug abuse          |
| Gastritis                  | Colon/ovarian/breast cancer |
| Stroke/high blood pressure | Diabetes                    |
| Heart disease              | Glaucoma                    |

Current health of your family (if deceased, at what age & from what condition):

Mother \_\_\_\_\_

Father \_\_\_\_\_

Brother(s) \_\_\_\_\_

Sisters (s) \_\_\_\_\_

Children \_\_\_\_\_

Who lives in your house? \_\_\_\_\_

Current medications (prescription/over the counter/herbal): \_\_\_\_\_