Screening Location and Date: ________________________________
Insurance Number: ____

Wellness Clinic Health Information Form

Please Fill Out Form Completely and Legibly

Date: ______________________ Age: ___________ Sex: M F

Name: ____ Birthdate: ________________

Phone Number: ______________________ Email: ____

Address: ____

Have you participated in a CostCare screening previously? If so, when? ___________________

Have you visited one of our CostCare locations for your personal health needs? _____________

Do you smoke or use chewing tobacco? Y N
Pack(s) per day _______ Can(s) per day _______ How many years? __________________

Ongoing Medical Concerns: ____

List any medications you are currently taking: ____

Primary Care Provider: ____________________ **Last Menstrual Cycle:** _______________

Please provide brief information regarding any immediate family member who has or had:

Heart Attack:

Heart Disease:

Diabetes:

Cancer:

Office Use Only

Blood Pressure: ______________ Height: ______________ Weight (lbs) __________

Waist Circumference: __________ BMI: ________________

Urine Dip Results: PH ________________ Spec Gravity ________________

Protein ______________ Glucose ____________________

Blood ______________ Misc. ______________________

☐ Urine Entered ☐ Labs Verified in PP ☐ Vitals Entered ☐ Demographics Entered Info to PCP