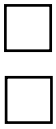

Patient Name _____ Date of Birth _____

Family History – Please list all medical problems in your family, including cause of death if appropriate
☐ I don't have a family history to share
Mother:
Father:
Sibling:
Sibling:
Other family members:

Review of Systems: Mark the symptoms you have had in *the past **30** days and want to discuss today*

Constitutional	**Head and Throat**	**Lungs and Heart**	**Gastrointestinal**
• Chills ☐ • Fatigue ☐ • Fever ☐ • Night Sweats ☐ • Weight Gain ☐ • Weight Loss ☐	• Ear Pain ☐ • Eye Discharge ☐ • Eye Pain ☐ • Hearing Loss ☐ • Sinus Pressure ☐ • Sore Throat ☐ • Vision Changes ☐ • Snoring ☐	• Cough ☐ • Shortness of Breath ☐ • Wheezing ☐ • Difficulty Breathing ☐ • Chest Pain ☐ • Swelling of Hands or Feet ☐ • Palpitations ☐ • Fainting ☐	• Abdominal Pain ☐ • Blood in Stool ☐ • Change in Stool ☐ • Constipation ☐ • Diarrhea ☐ • Nausea ☐ • Vomiting ☐ • Heartburn ☐ • Change in Appetite ☐
Reproductive: Female	**Reproductive: Male**	**Urinary**	**Skin**
• Hot Flashes ☐ • Menstrual Pain ☐ • Irregular Periods ☐ • Vaginal Discharge ☐ • Vaginal Itch ☐ • Pain with Sex ☐ • Decreased Libido ☐ • Sexual Dysfunction ☐ • Breast Discharge ☐ • Breast Lumps ☐ • Breast Pain ☐	• Decreased Libido ☐ • Erectile Dysfunction ☐ • Masses ☐ • Penile Discharge ☐ • Scrotum/Testicular Pain ☐ • Sexual Dysfunction ☐	• Painful Urination ☐ • Blood in Urine ☐ • Frequent Urination ☐ • Urinary Incontinence ☐ • Nighttime Urination ☐ • Flank Pain ☐ • Slow Stream ☐	• Acne ☐ • Itching ☐ • Change in Mole ☐ • Rash ☐ • Skin Masses or Lumps ☐ • Hair Loss ☐ • Skin Lesion ☐
Musculoskeletal	**Mental Health**	**Metabolic/Endocrine**	**Neurologic**
• Joint Pain ☐ • Muscle Weakness ☐ • Neck Pain ☐ • Joint Stiffness ☐ • Back Pain ☐ • Joint Deformity ☐	• Anxiety ☐ • Depression ☐ • Difficulty Sleeping ☐	• Cold Intolerance ☐ • Heat Intolerance ☐ • Extreme Thirst ☐ • Extreme Hunger ☐	• Dizziness ☐ • Numbness/Tingling ☐ • Extremity Weakness ☐ • Headache ☐ • Memory Loss ☐ • Seizures ☐ • Tremors ☐ • Change in Gait ☐ • Increased Falls ☐
	Hematologic/Lymph	**Environmental**	
	• Easy Bleeding ☐ • Easy Bruising ☐ • Swollen Lymph Nodes ☐	• Contact Allergy ☐ • Environmental Allergy ☐ • Food Allergy ☐ • Seasonal Allergy ☐	

Patient Name _____ Date of Birth _____

General Health

In general, would you say your health is: ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

How would you describe the condition of your mouth and teeth – including false teeth or dentures:
☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

In general, how satisfied are you with your life? ☐Very Satisfied ☐Satisfied ☐Dissatisfied ☐Very Dissatisfied

How often do you find yourself confused by health information like what your medical provider tells you?
☐Usually ☐Sometimes ☐Rarely

Do you have a:
- Medical power of attorney? ☐Yes ☐No
- Living will/advanced directives? ☐Yes ☐No

How interested are you in making changes to improve your health?
☐Very interested ☐Somewhat interested ☐Not interested

If interested, what health change do you want to make? _____

Wellness

Average hours of sleep per night? _____ **Do you feel rested when you awaken?** ☐Yes ☐No

Average hours of physical activity per week? _____ Type(s) of activity: _____

How often do you eat fruits or vegetables? ☐Every meal ☐With most meals ☐Once a day ☐Less than once a day

How often do you consume foods or drinks that are high in added sugar? (Ex: soda, sweetened drinks, desserts, etc.)
☐3+ times a day ☐1-2 times a day ☐A few times a week ☐Less than once a week

How often do you eat fried or highly processed foods? (Ex: fast food, bacon, potato chips, etc.)
☐3+ times a day ☐1-2 times a day ☐A few times a week ☐Less than once a week

Do you consume caffeine? ☐Yes ☐No **If yes, how much per day?** _____

Behavioral Health

Do you have significant stress with any of the following?
☐Work ☐Finances ☐Legal Issues ☐Housing ☐Family Concerns ☐Relationships ☐Other: _____ ☐N/A

How often do you get the social and emotional support you need? ☐Usually ☐Sometimes ☐Rarely

Are religious or spiritual beliefs or practices something that you use for support? ☐Usually ☐Sometimes ☐Rarely

Think about the <u>last 2 weeks</u> as you answer the following questions:

How often have you had little or no interest in daily activities?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

How often have you been bothered by feeling down, depressed, or hopeless?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

How often have you felt nervous, anxious, or on edge?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

How often were you not able to stop worrying or control your worry?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

Tobacco Use

What tobacco or vapor products have you used?
☐Cigarettes ☐Chew ☐Vapor/e-cigarettes ☐Other_____ ☐None

If you've ever smoked cigarettes, answer the following:(otherwise, skip to next section)
How many cigarettes per day? _____ Number of years used: _____ If you stopped, when did you quit? _____

Alcohol and Drug Use

How often do you have a drink containing alcohol?

Patient Name _____ Date of Birth _____

☐ Never ☐Monthly or less ☐2-4 times a month ☐2-3 times a week ☐4 or more times a week

How many drinks containing alcohol do you have on a typical day when you were drinking in the past year?

☐1-2 ☐3-4 ☐5-6 ☐7-9 ☐ 10 or more ☐I don't drink

How often do you have four or more (six or more for males) drinks on one occasion in the past year?

☐ Never ☐Less than monthly ☐ Monthly ☐ Weekly ☐Daily or almost daily

Have you ever had a problem with alcohol or binge drinking in the past? ☐Yes ☐No

Have you ever used recreational drugs?

☐No history of use ☐ Use or have used: Type(s): _____ Frequency of use: _____

Sexual History

Are you sexually active? ☐Yes ☐Formerly ☐No

How many sexual partners have you had in the past 3 months? _____

Have you had sex with: ☐Men ☐Women ☐Both

Do you use birth control? ☐Always ☐Sometimes ☐No

If so, what types? ☐Condoms ☐N/A

☐Other: _____

Do you desire to start or change contraception?

☐ No ☐Yes

Safety

How often do you need help with eating, grooming, dressing, toileting, or walking?	☐Often ☐Sometimes ☐Never
How often do you need help with cooking, banking, transportation, or housekeeping?	☐Often ☐Sometimes ☐Never
Do you ever drive after drinking or ride with a driver who has been drinking?	☐Often ☐Sometimes ☐Never
Do you fasten your seat belt when you are in a car?	☐Always ☐Sometimes ☐Never
Does anyone in your life hurt you or make you feel unsafe in any way?	☐Yes ☐I don't know ☐No
Are your firearms unloaded and locked away?	☐Yes ☐No ☐Don't have guns

Screenings - Please include date or year if known

☐Dental Exam	☐ Hepatitis C screening	☐HIV Screening
Colon Cancer Screening	☐Colonoscopy: _____ ☐ Stool Based test (FIT, stool card): _____	☐Sigmoidoscopy: _____ ☐CT Colonography: _____

Immunizations - Please include date or year if known

☐Pneumonia Vaccine	☐Tetanus Shot	☐HPV Vaccine
☐Shingles Vaccine	☐ Flu Shot (within the year)	☐MMR

Women's Health – Please include date or year if known

1st day of last period _____

Pap Smear ☐ Never	Chlamydia/Gonorrhea test ☐ Never	Mammogram ☐ Never	DEXA/Bone Density Scan ☐Never

Do you have any concerns about your periods or menopause? □ No □ Yes: Describe_____

Patient Signature: _____ Today's Date: _____

Date of Birth: _____