

MRN #: _____

FIN #: _____

CURRENT MEDICATIONS:

Please list your current medications (including over-the-counter medications and vitamins):

Medication

Dose

SOCIAL HISTORY:

Do you currently use tobacco of any kind? _____ YES _____ NO

What type(s) of tobacco do you/have you used?

_____ Cigarette _____ Pipe _____ Cigar _____ Chewing Tobacco

Other: _____

Are you a:

____ Current smoker daily? (Have smoked at least 100 cigarettes during your lifetime and still smoke daily)

____ Current smoke sometimes? (Do not smoke every day and have smoked fewer than 100 cigarettes in your lifetime)

____ Former smoker? (Smoked at least 100 cigarettes in your lifetime, but do not currently smoke)

____ Never smoked? (have not smoked 100 or more cigarettes in your lifetime)

How much do/did you smoke per day?: _____

What age did you start smoking?: _____ What age did you stop smoking?: _____

Do you drink alcohol of any kind? _____ YES _____ NO _____ PAST

If yes, please indicate what kind(s) of alcohol: _____ Beer _____ Wine _____ Liquor

How often do you drink alcohol?

____ 1-2 times per year

____ 1-2 times per month

____ 1-2 times per week

____ 3-5 times per week

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- Daily
- several times per day

Do you have any history of substance abuse (i.e. alcohol, drugs)?: YES NO

If yes, what kind: _____

Are you currently using this/these substances? YES NO

If yes, which ones and with what frequency? _____

What is your current employment status?:

- Employed
- Retired
- Student
- Unemployed
- Caretaker
- Disabled

What do/did you do for work? _____

Students:

Name of School: _____

Grade Level: _____

What is your highest level of education?

- Elementary
- Middle School
- High School
- Some College
- College Degree
- Post-graduate

With whom do you live?

- Alone
- With children
- With spouse/significant other
- With mother
- With father
- With siblings
- Other (please qualify): _____

Have you ever felt unsafe in your home?: YES NO

What type of diet do you follow?

- Regular (none)
- Calorie Restricted
- Diabetic
- Vegetarian
- Other (please qualify): _____

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Do you exercise? YES NO

If yes, how often do you exercise?

1-2 times per week

3-4 times per week

5-6 times per week

Daily

What type of exercise do you do?

Walking

Running

Cycling

Aerobics

Weight Lifting

Swimming

Yoga

Other (please qualify): _____

How would you rate your physical condition today? Excellent Good Fair Poor

Are you having any pain today? YES NO

PAST MEDICAL HISTORY:

Please list all medical conditions you have been diagnosed with or treated for:

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FAMILY MEDICAL HISTORY:

Have any of your family members have ever had any of the following:

<u>High Blood Pressure:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Heart Disease:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Stroke:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Diabetes:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Cancer:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Osteoporosis:</u> Father Mother Brother Sister Brother Sister Grandparents All Family
<u>Glaucoma:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Bleeding disease:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Anxiety, depression, etc.):</u> Father Mother Brother Sister Brother Sister Grandparents All Family	<u>Drug/ alcohol addiction:</u> Father Mother Brother Sister Brother Sister Grandparents All Family	Other:	

PAST SURGICAL/PROCEDURAL HISTORY:

Please list any surgical procedures you have ever had and their approximate date:

Procedure

Date

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REVIEW OF SYSTEMS:

Check ANY POSITIVE symptoms or problems you have experienced in RECENT MONTHS:

	Yes	No
Fevers		
Chills		
Weight Loss		
Weight Gain		
Changes in vision		
Double Vision		
Light sensitivity		
Change in hearing		
Congestion		
Sore Throat		
Difficulty Swallowing		
Dentures		
Shortness of breath		
Cough		
Wheezing		
Chest pain, pressure, tightness		
Palpitations		
Swelling in legs		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Heartburn		
Abdominal Pain		
Pain with urination		
Blood in urine		
Urinary frequency		
Genital discharge		
Easy bruising or bleeding		
Excessive thirst		
Heat or cold intolerance		
Joint Pain		
Muscle pain		
Pain in legs when walking		
Skin rashes		
Abnormal skin lesions: moles, growth, etc		
Balance problems		
Numbness or tingling (especially in feet)		
Headaches		
Anxiety		
Depression		

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Women			
Age when you started menstrual cycles?			
Age when you stopped menstrual cycles?			
Are you having regular menstrual cycles now?			
How many times have you been pregnant?			
How many living children do you have?			
Have you ever had an elective termination of pregnancy (abortion)?			
Have you ever had a miscarriage?			
Could you be pregnant now?			
Any breast discharge not related to pregnancy or nursing?			
Men			
Prostate or urinary problems?			
Loss of sexual desire or erectile dysfunction?			

Provide most recent dates for the following:	Date	Performed Where?	Result?
Eye Examination (Eye Doctor)			
Podiatrist Visit (Foot Doctor)			
Colonoscopy			
Mammogram			
Pneumonia Vaccination			
Influenza Vaccination (Flu shot)			
Tetanus Vaccination (Td, Tdap, "whooping cough shot")			

Depression Screening (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following: (Check the appropriate box to the right)	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleep too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				

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6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				
	Not at all	Somewhat difficult	Very Difficult	Extremely Difficult
If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people				

PHQ-9 SCORE = _____ (to be scored by medical staff)

(Score 1-4 = Minimal depression; 5-9= Mild depression; 10-14= Moderate depression; 15-19= Moderately severe depression; 20-27= Severe depression)

✓	Recent Fall History	HOW DID YOU FALL? Circle all that apply					
	NO FALLS in past year						
	1 - 2 FALLS in past year	Trip	Slip	Dizziness	Lost balance	Leg/s gave way	Other
	3 OR MORE FALLS in past year	Trip	Slip	Dizziness	Lost balance	Leg/s gave way	Other
Do you feel unsteady when standing or walking?					<input type="checkbox"/> Yes		<input type="checkbox"/> No
Do you worry about falling?					<input type="checkbox"/> Yes		<input type="checkbox"/> No

Do you have a living will, advanced directives, healthcare proxy, or healthcare power of attorney?
 ___ YES ___ NO

If no, are you interested in information about the above items?
 ___ YES ___ NO

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____