NAME____D0B_________________________TODAY'S DATE_________

Do you currently have concerns with any of the following?

Appetite	YES NO	Unintentional Weight Loss/Gain	YES NO	Night Sweats/Fever	YES NO
Sleeping Difficulty	YES NO	Activity Level	YES NO	Vision Changes	YES NO
Eye Pain	YES NO	Hearing Problems	YES NO	Ear Pain	YES NO
Difficulty Swallowing	YES NO	Nose Difficulty	YES NO	Chest Pain	YES NO
Shortness of Breath/ Difficulty Breathing	YES NO	Leg/Arm Swelling	YES NO	Persistent Cough	YES NO
Wheezing	YES NO	Nausea/Vomiting	YES NO	Abdominal Pain	YES NO
Recurrent diarrhea	YES NO	Constipation	YES NO	Blood in Stool	YES NO
Urine Incontinence	YES NO	Frequent Urination	YES NO	Blood in Urine	YES NO
Loss of Sex drive	YES NO	Joint Pain/Swelling/ Musculoskeletal Deformity	YES NO	Rash/Skin Problems	YES NO
Memory Problems/ Confusion	YES NO	Headaches	YES NO	Dizziness	YES NO
Depression	YES NO	Anxiety	YES NO	Excessive Thirst	YES NO
Excessive Urination	YES NO	Heat Intolerance	YES NO	Easy Bruising/Bleeding/ Swollen nodes	YES NO

Any new allergic reactions to
Medications or Foods? YES NO If yes, please list: ____

Are you working? YES NO RETIRED Occupation____

Are you currently: MARRIED SINGLE SINGLE in relationship DIVORCED WIDOWED SEPARATED

Do you have children? YES NO How many?________

Please check: Are you a CURRENT SMOKER ______ I've smoked ___________ packs per day/week for _____________years

FORMER SMOKER ______ Quit date _________ __________packs per day for _________ years

NEVER A SMOKER ______

Do you currently have exposure to Secondhand Smoke? YES NO Past history of exposure to secondhand smoke YES NO

If yes, from ____ for how long? __________________________________

Alcohol Use: None Rare Occasional 1-2/day 3-4/day >5/day

Is there any Family History of alcohol problems? YES NO If yes, which family member(s) ________________________________

Do you have a history of recreational drug use? Current Use YES NO What drug(s)? _____________________________________

Past Use YES NO What drug(s)? _____________________________________

Exercise: I exercise ______ times per week. Type of exercise____

OR I rarely exercise

Diet: I try to eat healthy *OR* My diet needs improvement Explain:____

Are you sexually active? YES NO Sexual Orientation: ____

SINCE YOUR LAST PHYSICAL HERE, PLEASE LIST ANY CHANGES:

*Have you seen any new specialists or been diagnosed with any condition by another specialist since last physical? YES NO If yes, please list:____

*Have you had any surgery since last physical with us? YES NO If yes, where and when:_________________________________

*Has any family member(s) been diagnosed with a new medical or psychiatric condition since you were last seen? YES NO
If so, who and what condition:____

*Have you had a colon screening since your last physical? (Colonoscopy, Cologuard, Fit, Hemoccult Cards) YES NO If yes, when and with who:____

*Have you had an eye exam since your last physical? YES NO If yes, when and with who: _________________________________

If female: SINCE YOUR LAST PHYSICAL HERE

Have you had pap smear elsewhere? YES NO If yes, where____

Have you had mammogram elsewhere? YES NO If yes, where____

Have you had a DEXA scan elsewhere? YES NO If yes, where____

Are you interested in receiving information on Advanced Care Planning? YES NO

Please review the attached page. Make any necessary changes to the Patient Care Team (list of specialists that you see). Put a check mark next to the specialist if you "self-referred". Please provide Emergency Contact. If you have a caregiver, please list.

Name____Date__________________________

Emergency Contact: Name/Phone ____

Do you have a caregiver? YES or NO
If Yes: Name__________________________________ Phone_______________________________
Relationship: ___________________________
If you have a caregiver, do we have a signed HIPAA form allowing us to speak with them? YES or NO
If NO, please complete a HIPAA form during your visit if you would like us to be able to speak to them about your care.

PLEASE LIST ANY SPECIALISTS THAT YOU SEE:

	Name of Doctor/Address /Phone	**Last Visit**	Check if Self-Referred
PODIATRY (Foot Doctor)			☐
OPHTHALMOLOGY (Eye Doctor)			☐
CARDIOLOGY			☐
ORTHOPEDICS			☐
GASTROENTEROLOGY			☐
RENAL/KIDNEY (NEPHROLOGY)			☐
UROLOGY			☐
PSYCHIATRY (Prescribes Meds)			☐
PSYCHOLOGY (Talk Therapy)			☐
RHEUMATOLOGY			☐
NEUROLOGY			☐
DERMATOLOGY			☐
ENDOCRINOLOGY			☐
ALLERGIST			☐
GYNECOLOGY			☐
ENT (Ear/Nose/Throat)			☐
PAIN MANAGEMENT			☐
OTHER(S)			☐

Patient Name: ______________________ DOB: ______________ Date: ____________

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the **following problems?**	Not At all	Several Days	More **Than Half** the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals ________ + ________ + ________ + ________

Add Totals Together ____________

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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