Please Circle if it applies to you

Single Married Partner Divorced Widowed Separated

Asian Black Hispanic Multiethnic Native American Pacific Asian White

Years of Schooling/Education: 1-6 7-12 13-16 17+

Exercise: yes no sometimes

Retired Disabled Student Employed Other

Preferred Language :_____

Medications refill 90 30 days

_____

_____

_____

_____

_____

_____

_____

_____

RISK FACTORS

Have you had any toxic exposures? Y N

Have you had a blood transfusion? Y N

Any serious trauma or injury? Y N

Do you have pets? Y N

Do you have "End of Life" directives? Y N

Any recent travel outside the USA? Y N

FAMILY HISTORY

Diabetes bro sis mother father grandparent other

Heart bro sis mother father grandparent other

Hypertension bro sis mother father grandparent other

Cancer who/where

TB bro sis mother father grandparent other

Stroke bro sis mother father grandparent other

Constitutional

Sweats
Chills
Fevers
Trouble sleeping
Appetite change
Weight change
Abuse • Fear harm

Head Neck

Vision problem°
Eye Pain
Headaches
Dizzy • Vertigo
Hearing problem°
Ringing in the ears
Hoarseness
Sinus • Nose bleeds
Smell • Taste
Dry mouth • Sores
Teeth • Gums
Dentures
Neck or jaw pain
Goiter
Swollen glands
Tics • Tremors
Memory loss

L • R Handed

Can you	√ Yes
Toilet Self	
Feed Self	
Dress Self	
Groom Self	
Bathe Self	
Walk 50 ft	
°Use a walker or cane?	

Gastrointestinal

Swallowing problem
Heartburn
Bloating
Ulcers
Abdominal pain
Nausea • Vomiting
Diarrhea
Constipation
Blood in stool
Mucus in stool
Food intolerances
Jaundice
Hemorrhoids

Genitourinary

Sexually active
Multiple partners
Infections
Change in sex drive
Menstrual disorder
Menopause
Incontinence°
Frequent urination°
Urge to urinate
Painful urination
Blood in Urine
Discharge
Groin itching
Awaking to urinate
Change in stream

Last period	
Pregnancies	
Live births	
Abortions	

Respiratory

Shortness of breath
Cough
Sputum
Coughed up blood
Choking at night
Breathless flat in bed
Snoring
Breathless with walking

Cardiovascular

Chest pressure
Chest pain
Palpitations
Wake up breathless
Ankle swelling
Leg cramping
Varicose veins
Cold feet or hands
Passing out

Musculoskeletal

Problem walking°
Joint stiffness or pain
Joint swelling
Muscle aches
Muscle weakness°
Change in moles
Change in nails
Change in hair
Rashes • Bumps • Bruises
Fractures
Numbness • Tingling
Low Back Pain
Phlebitis
Deformity • Amputation
Fall in last 3 months°°°

YOUR MEDICAL HISTORY

Diabetes Heart condition Hypertension Stroke

High Cholesterol COPD Asthma Pneumonia

Sleep Apnea Depression Thyroid TB Arthritis Ulcers

Anemia HIV Hepatitis Poor Circulation Blood clots

Cancer Kidney stones Ulcers Glaucoma Seizures

YOUR SURGICAL HISTORY

Gallbladder Tonsils Appendix Implants Cancer

R L Hip • R L Knee • R L Foot

Stomach Colon R L Hernia Bladder Prostate

R L Breast Hysterectomy R L Cataract

Pacemaker Defibrillator Stents Bypass Heart-Valve

Falls Screen _____ °

≥3 high risk °°°

1-2 moderate risk °°

0 low risk

PHQ4 screen ≤ 5 mild ≥ 6 do PHQ9	0	1	2	3
1. Do you feel nervous or anxious?	No	sometimes	most of the time	all the time
2. Are you able to control or stop your worry?	Yes	mostly	sometimes	no
3. Loss of interest in doing things or having fun?	No	sometimes	most of the time	all the time
4. Do you feel sad, hopeless, or down?	No	sometimes	usually	all the time