Please note that we can help you fill out ANY or ALL parts of this form over the phone and during your visit. You can also skip sections if desired.
If you want, we can also find/review information from your previous providers

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Reason for Visit Today: _____

How did you hear about us?: _____

Partner's name (if applicable): _____

Do you have any children? _____ _____	Hobbies? _____ _____
Most Important people in your life? _____ _____	Sports? _____ _____
Pets? _____ _____	Volunteer? _____ _____

Health Care Representative/Proxy (to make healthcare decisions if suddenly incapacitated like hit by a car): _____ Phone #: _____ Relationship: _____

Advanced Directives (check all that apply):

- ☐ Living Will
- ☐ OR Advanced Directives
- ☐ POLST
- ☐ Healthcare Represenative/DPOA for Healthcare paperwork filled out
- ☐ Other: _____

Veteran:

☐ Yes ☐ No

If a Veteran, What medical/pharamacy services do you receive from VA?: _____

_____

Education Level: What is the highest grade or level of school that you have completed? ☐ 8th grade or less ☐ Some high school, but did not graduate ☐ High school graduate or GED ☐ Some college or 2 year degree ☐ 4-year college graduate ☐ More than a 4-year college degree ☐ Prefer not to answer	**Literacy Screening** How often do you need help with READING or with UNDERSTANDING instructions, pamphlets, or other written material from your provider or pharmacist? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐ Prefer not to answer

Employment Status: ☐ Part-time ☐ Full-time ☐ Retired ☐ Disabled ☐ Unemployed looking for work ☐ Underemployed looking for work ☐ Unemployed Not Looking for Work Current Employer (if applicable): _____	Occupation(s):_____ Occupational Exposures (past and present): ☐ None ☐ Loud noise ☐ Violence ☐ Air Pollutants ☐ Chemical exposures ☐ Other_____ Details: _____

Social Determinants of Health Screenings:

In the past 12 months, have you been living in stable housing that you own, rent, or stay in as part of a household?

☐ yes ☐ no ☐ unknown ☐ prefer not to answer

In the next two months, are you worried you may **NOT** have stable housing (rent, own, or stay in as part of a household)?

☐ yes ☐ no ☐ unknown ☐ prefer not to answer

In the past month, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

☐ yes ☐ no ☐ If yes, specify: _____

In the past year, have you or any family member you live with been unable to get any of the following when it was really needed? (check all that apply).

☐ food ☐ clothing ☐ utilities ☐ child care
☐ medicine or any health care (medical, dental, mental health, vision) ☐ phone ☐ Other: _____ _____ ☐ I choose not to answer this question

Gender Identity/pronouns (male, female, fluid, etc.): _____

Sexual Preference (attracted to men, women, both, prefer not to say): _____

Cultural Preferences: _____

Preferred Language(s) and interpreter preferences (if applicable):_____

Do you ALWAYS feel safe in your home/place of residence?

☐ yes ☐ no

Do you have any allergies to Meds?

☐ yes ☐ no

Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____

Do you have any allergies to foods or other substances?

☐ yes ☐ no

Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____
Allergy: _____
Reaction:_____

Do you know your family medical history?

☐ yes ☐ no

If yes, Mark all that apply:

- ☐ Diabetes
- ☐ Asthma
- ☐ Coronary Artery Disease
- ☐ Heart Attack-MI
  Before age 60? ☐ Yes ☐ No
- ☐ Stroke or TIA (mini stroke)
  Before age 60? ☐ Yes ☐ No
- ☐ Chronic Kidney Disease
- ☐ Suicide attempts
- ☐ Mental illness besides anxiety or depression
- ☐ Autoimmune disease
  - ☐ Type I diabetes (onset usually very young)
  - ☐ Rheumatoid arthritis
  - ☐ Celiac disease
  - ☐ Lupus
  - ☐ Grave's disease (thyroid)
  - ☐ Hashimoto's thyroiditis (thyroid)
  - ☐ Multiple sclerosis
  - ☐ Inflammatory bowel disease
  - ☐ Myasthenia gravis
  - ☐ Addison's Disease
  - ☐ Sjogren's syndrome
- ☐ Cancer (specify)
  - ☐ Bladder
  - ☐ Brain
  - ☐ Breast
  - ☐ Colon
  - ☐ Kidney
  - ☐ Lung
  - ☐ Melanoma
  - ☐ Pancreas
  - ☐ Prostate
  - ☐ Other _____
- ☐ Other Medical Problems: _____

Medications and supplements (medicine, amount, how you take it):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

Tobacco Use:	Alcohol Use:
☐ Never ☐ Current ☐ Former (last use > 3 months ago), Date _____ If Current or Former, What type? ☐ cigarettes ☐ chew ☐ vape How many Years?_____ Avg Amt per day_____	☐ Never ☐ Current ☐ Former (last use > 3 months ago), Date Last Use (if former) _____ If current, how many days in the last year have you had 4 or more drinks (if a woman) or 5 or more drinks (if a man)? _____days

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (valium, benzodiazepines), barbituates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin). Have you ever used recreational drugs or used a prescription medication for non-medical reasons?

- ☐ Never
- ☐ Current
- ☐ Former (Quit > 3 months ago), Date _____ Substance: _____
- ☐ Former and Current (specify substances): _____
- ☐ Multiple Former (specify sbustances): _____

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? _____

Nutrition Assessment

As best you can remember, list all the foods and drinks you have had in the last 24 hours:

1. Breakfast: _____
   _____
2. Lunch:_____
   _____
3. Dinner:_____
   _____
4. Snacks and drinks: _____

Recall foods and drinks you have on a typical day:

1. Breakfast: _____
   _____
2. Lunch:_____
   _____
3. Dinner:_____
   _____
4. Snacks and drinks: _____

Do you have concerns about your weight?

☐ yes ☐ no

Details if applicable: _____

Physical Activity Assessment

Do you exercise regularly?

☐ yes ☐ no

If Yes, think about your weekly routine and guess/specify what you do below (walking, aerobics, weights, heavy house/yard chores, yoga, resistance bands, etc)

Activity _____, Min/Time _____ , Times/Wk _____
Activity _____, Min/Time _____ , Times/Wk _____
Activity _____, Min/Time _____ , Times/Wk _____
Activity _____, Min/Time _____ , Times/Wk _____
Activity _____, Min/Time _____ , Times/Wk _____
Activity _____, Min/Time _____ , Times/Wk _____
Activity _____, Min/Time _____ , Times/Wk _____
Activity _____, Min/Time _____ , Times/Wk _____

Sexual Health Assessment (optional)

Are you sexually active?

☐ yes ☐ no

What are your family plans?

☐ Want kids (or more kids) as soon as possible ☐ want kids (or more kids) within a year ☐ want kids (or more kids) but not for at least another year	☐ unsure about having kids (or more kids) ☐ Definitely do not want kids (or more kids) ☐ Other: _____ _____

Do you use birth control?

☐ yes ☐ no

If you or your partner(s) use birth control, what methods? (mark all that apply):

☐ birth control implant ☐ IUD (intrauterine device) ☐ Birth control shot ☐ Birth control vaginal ring ☐ Birth control patch ☐ Birth control pill ☐ External condom ☐ Internal condom	☐ Diaphragm ☐ Birth control sponge ☐ Spermacide and gel ☐ Cervical cap ☐ Fertfility awareness (calendar) ☐ Withdrawal (pull out method)	☐ Breast feeding as birth control ☐ Outercourse and abstinence ☐ Sterilization (tubal ligation) ☐ Vasectomy

Would you like to discuss birth control options with your provider today?

☐ yes ☐ no

Higher Risk for sexually transmitted infections are the following (mark all that apply):

☐ Sexually active under age 25 (risk for chlamydia and gonorrhea)
☐ Multiple sexual partners (risk for chlamydia, gonorrhea, syphilis, trichomoniasis for women)
☐ Engage in sex for money (risk for chlamydia, gonorrhea, syphilis, trichomoniasis for women)
☐ New sex partner (risk for chlamydia, gonorrhea, syphilis, trichomoniasis for women)
☐ History of Sexually transmitted infection within the last 24 months (risk for chlamydia, gonorrhea, syphilis, trichomoniasis for women)
☐ Have a Sex partner that has (or might have) any risk factors (under age 25, multiple sexual partners, engages in transactional sex, history of sexually transmitted infection within the last 24 months)

*Additionally, depending on risk, HIV and Hepatitis B can be checked.

Do you want to talk to you provider about being checked for any sexually transmitted infections today?

☐ yes ☐ no

Are you interested in HIV PreP (pre-exposure prophylaxis) prescriptions?

☐ yes ☐ no

One-time Screenings

It is recommended that all adults over 18 be checked once for HIV. Have you been checked?

☐ yes ☐ no ☐ don't know

It is recommended that all adults over 18 be checked once for HBV (hepatitis B). Have you been checked? If you have documented history of HBV vaccine, you don't need to be checked.

☐ yes ☐ no ☐ don't know

It is recommended that all adults over 18 be checked once for HCV (hepatitis C). Have you been checked?

☐ yes ☐ no ☐ don't know

Have you ever been checked for tuberculosis?

☐ yes ☐ no ☐ don't know

Do you snore loudly (louder than talking)?	**Do you often feel tired, fatigued, or sleepy during the daytime?**	**Has anyone observe you stop breathing, gasp, or choke while sleeping?**
☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

Most Recent/Current Primary Care Provider (PCP): _____

Current Specialist (area of expertise): _____ Name/Business name: _____
What do they help you manage? _____
Current Specialist (area of expertise): _____ Name/Business name: _____
What do they help you manage? _____
Current Specialist (area of expertise): _____ Name/Business name: _____
What do they help you manage? _____
Current Specialist (area of expertise): _____ Name/Business name: _____
What do they help you manage? _____
Current Specialist (area of expertise): _____ Name/Business name: _____
What do they help you manage? _____
Current Specialist (area of expertise): _____ Name/Business name: _____

Medical Hospital Stays (besides surgical admissions)	**ED Visits**	Surgeries/Procedures
Reason: _____ Date: _____	Reason: _____ Date: _____	Surgery: _____ Date:_____
Reason: _____ Date: _____	Reason: _____ Date: _____	Surgery: _____ Date:_____
Reason: _____ Date: _____	Reason: _____ Date: _____	Surgery: _____ Date:_____
Reason: _____ Date: _____	Reason: _____ Date: _____	Surgery: _____ Date:_____
Reason: _____ Date: _____	Reason: _____ Date: _____	Surgery: _____ Date:_____

Upcoming Procedures and timeline: _____
Upcoming Procedures and timeline: _____
Upcoming Procedures and timeline: _____
Upcoming Procedures and timeline: _____
Upcoming Procedures and timeline: _____

Last Bone/DEXA Scan (often 65 and older): Date _____ Results: ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Unknown	If known, Last Colorectal Cancer Screenings (often 45 and older): ☐ FIT Date_____ ☐ Cologuard Date_____ ☐ Colonoscopy Date_____ ☐ Other Date_____	Men/Assigned Male at birth Prostate cancer screening (often 50 and older): PSA Date_____ PSA Result_____
Women/Assigend Female at birth Last mammogram (often 40+) _____ Last Period:_____ First Period (approx):_____	Women/Assigned Female at birth Last Cervical Cancer screening (often 21-65): PAP: _____ HPV: _____	Women/Assigned female at birth Total Pregnancies:_____ Total Live Births: _____ Total Miscarriages: _____ Total Abortions: _____ Total C-Sections: _____ Approx Last Menstruation: _____

Do you use sunscreen and/or sun-protective clothing when you go outside?

☐ N/A (I do not go outside) ☐ Always (or almost always) ☐ sometimes ☐ rarely or never

Do you use a helmet (when riding or operating bikes, motorcycles, roller skates, skateboards, scooters, downhill skies, other fast things that don't have airbags or cage-like protection)?

☐ N/A (I do not use those things) ☐ Always (or almost always) ☐ sometimes ☐ rarely or never

Do you wear a seatbelt when riding in cars?

☐ N/A (I do not ride in cars) ☐ Always (or almost always) ☐ sometimes ☐ rarely or never

Do you have working smoke detectors and carbon monoxide alarms where you live?

☐ N/A (I live outside or in my car) ☐ Always (or almost always) ☐ sometimes ☐ rarely or never

Recent Trauma or Loss (loss of a loved one, loss of friendship, loss of family, divorce, job loss, exposure to violence, exposure to sexual abuse, exposure to a serious accident, exposure to a serious illness, loss of function, loss of housing, etc):

☐ yes ☐ no

Specify: _____

_____

_____

_____

_____

Last Eye Exam: _____

Last Hearing Exam: _____

Last Dentist Visit: _____

Last Cholesterol Check: _____

What is Important to you right now? _____

_____

What are your goals right now (short and long term)? _____

_____

Latest news related to you, family, friends _____

_____

Past Medical History (page 1 of 2): Mark for any condition that you have been diagnosed with, been treated for, have taken prescription medicine for, and/or are currently taking medicine for:

General
- ☐ insomnia
- ☐ restless leg syndrome

Endocrine
- ☐ diabetes
- ☐ pre-diabetes
- ☐ thyroid condition
- ☐ parathyroid condition
- ☐ mineral or vitamin deficiency (i.e. B, D, Iron, Folate)
- ☐ electrolyte problem (i.e. potassium, sodium, magnesium)
- ☐ Other_____

Head/Eyes/Ears/Nose/Throat
- ☐ allergy issues
- ☐ sinus issues
- ☐ chronic eye condition
- ☐ cataracts
- ☐ macular degeneration
- ☐ retinopathy
- ☐ dry eye syndrome
- ☐ glaucoma
- ☐ need or use reading glasses
- ☐ need glasses to drive
- ☐ legally blind
- ☐ hearing impairment
- ☐ need or use hearing aides
- ☐ Cold Sores
- ☐ Other _____

Pulmonary
- ☐ ever diagnosed with TB
- ☐ respiratory problems
- ☐ asthma
- ☐ COPD/emphysema
- ☐ Use oxygen
- ☐ Sleep apnea
- ☐ Use CPAP. Last check? _____
- ☐ Other_____

Cardiovascular
- ☐ Heart problems
- ☐ irregular heartbeat
- ☐ Atrial fibrillation
- ☐ Heart block
- ☐ Have a Pacemaker
- ☐ Have a defibrillator

Last check? _____

- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart Valve Problems
- ☐ Angina
- ☐ Coronary artery disease
- ☐ Peripheral vascular disease
- ☐ Varicose veins
- ☐ Aortic Aneurysm
- ☐ Carotid Artery Problem

Gastrointestinal
- ☐ Heartburn/Acid Reflux
- ☐ Peptic ulcer disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea and/or vomiting
- ☐ Hiatal hernia
- ☐ Abdominal hernia
- ☐ Groin hernia
- ☐ Ostomy/ileostomy
- ☐ Esophageal problems
- ☐ Dyspepsia (indigestion)
- ☐ Irritable Bowel Disease
- ☐ Bowel Disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Fatty Liver/NASH
- ☐ Hemochromatosis
- ☐ Pancreatitis
- ☐ Other _____

Genitourinary
- ☐ Kidney Problem
- ☐ Kidney stones
- ☐ Bladder Problem
- ☐ Chronic kidney disease (CKD)
- ☐ CKD stage if known_____
- ☐ Urinary retention
- ☐ Urinary incontinence
- ☐ Type of incontinence if known _____
- ☐ Foley catheter
- ☐ Pessary
- ☐ Urostomy
- ☐ Nephrostomy
- ☐ Other _____

Musculoskeletal
- ☐ Spinal Problems
- ☐ Degenerative disc disease
- ☐ Scoliosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Joint problems
  - ☐ Jaw Joint(s)
  - ☐ Shoulder joint(s)
  - ☐ Elbow Joint(s)
  - ☐ Wrist Joint(s)
  - ☐ Finger/Hand Joint(s)
  - ☐ Hip Joint(s)
  - ☐ Knee Joint(s)
  - ☐ Ankle Joint(s)
  - ☐ Toe/Foot Joint(s)
- ☐ Bunion
- ☐ Trigger finger
- ☐ Other_____

Past Medical History (page 2 of 2): Mark for any condition that you have been diagnosed with, been treated for, have taken prescription medicine for, and/or are currently taking medicine for:

Skin
- ☐ Chronic Skin Conditions
- ☐ Dermatitis
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Skin Cancer besides Melanoma
- ☐ Squamous Cell Cancer
- ☐ Basal Cell Cancer
- ☐ Actinic keratosis
- ☐ Wounds lasting longer than 1 month
- ☐ Genital herpes
- ☐ Other_____

Neurology
- ☐ Hx of TIA (mini-stroke)
- ☐ Hx of Stroke (CVA)
- ☐ Seizures/Epilepsy
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Mild Cognitive Impairment
- ☐ Dementia
- ☐ Parkinson's Disease
- ☐ Parkinsonism
- ☐ Alzheimer's Disease
- ☐ Lewy Body Dementia
- ☐ Fronto-temporal Dementia
- ☐ Vascular Dementia
- ☐ Huntington's Disease
- ☐ Tremor
- ☐ Involuntary movements
- ☐ Traditive dyskinesia
- ☐ Neuropathy
- ☐ Multiple sclerosis
- ☐ Cerebral palsy
- ☐ Spina Bifida
- ☐ ALS/Lou Gehrig's

Hematology/Oncology
- ☐ Clotting problem
- ☐ History of Clot(s) in leg(s)
- ☐ History of Clot(s) in lung(s)
- ☐ Bleeding problem
- ☐ Anemia
- ☐ Blood cancer
- ☐ Other cancer
  - ○ Adrenal
  - ○ Anal
  - ○ Bladder
  - ○ Bone
  - ○ Brain
  - ○ Breast
  - ○ Cervical
  - ○ Colon
  - ○ Endometrial
  - ○ Esophagus
  - ○ Gallbladder
  - ○ Kidney
  - ○ Liver
  - ○ Lung
  - ○ Lymph nodes
  - ○ Melanoma
  - ○ Ovarian
  - ○ Pancreas
  - ○ Peritoneal
  - ○ Prostate
  - ○ Rectal
  - ○ Stomach
  - ○ Testicular
  - ○ Thyroid
  - ○ Uterus
  - ○ Vagina
  - ○ Vulvar
  - ○ Unknown site
  - ○ Other _____
- ☐ Exposure to radiation therapy

Where?_____

- ☐ Exposure to chemotherapy

Immunology/Autoimmune
- ☐ Autoimmune disease
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus
- ☐ Celiac
- ☐ Sjogren Syndrome
- ☐ Myasthenia Gravis
- ☐ Scleroderma
- ☐ Autoimmune hepatitis
- ☐ Addison disease
- ☐ Type 1 diabetes
- ☐ HIV
- ☐ AIDS
- ☐ On immunosuppressant drugs (DMARDS, steroids)

Gender
- ☐ Benign Prostatic Hypertrophy
- ☐ Erectile Dysfunction
- ☐ Herpes
- ☐ HPV
- ☐ Vaginal atrophy

Psychiatry
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Eating disorder
- ☐ Schizophrenia
- ☐ Post Traumatic Stress Disorder
- ☐ Attention Deficit Disorder
- ☐ Personality Disorder
- ☐ Other _____

Mark √ for **ALL** that apply lately (last 3-6 months), **especially** if it is:

new, or **changing (especially if worse)**, or **something you want to work on**

- ☐ Memory issues
- ☐ Recent Falls
- ☐ Balance issues
- ☐ Coordination issues
- ☐ Trouble Finding Words
- ☐ Trouble Speaking
- ☐ Fever
- ☐ Chills
- ☐ Sweats and/or night sweats
- ☐ Feeling ill
- ☐ Feeling low energy
- ☐ Passing Out
- ☐ Weight loss without trying (at least 10 lbs in 6 months or less)
- ☐ Weight gain without trying (at least 10 lbsi n 6 months or less)
- ☐ Sleep Problems
- ☐ Loud Snoring
- ☐ Excessive thirst
- ☐ Excessive peeing
- ☐ More sensitive to Cold or heat
- ☐ Frequent infections or colds
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Rigid / Stiff
- ☐ Numb or Tingling
- ☐ Headaches
- ☐ Lightheadedness
- ☐ Dizziness
- ☐ Head Spinning
- ☐ Head injury
- ☐ Vision Changes
- ☐ Double vision
- ☐ Blurry vision
- ☐ Flashing lights
- ☐ Floaters
- ☐ Eye pain
- ☐ Sensitive to Light
- ☐ Itchy eyes
- ☐ Eye drainage
- ☐ Dry eyes
- ☐ Eyelid problems
- ☐ Hearing changes
- ☐ Ringing in ears
- ☐ Hard of hearing
- ☐ Ear pain
- ☐ Ear drainage
- ☐ Ear fullness
- ☐ Change in smell
- ☐ Nose bleeds
- ☐ Nose pain
- ☐ Dry nose
- ☐ Nose stuffiness
- ☐ Sinus fullness or congestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Bloody or black stools
- ☐ Abdominal pain
- ☐ Frequent use of laxatives
- ☐ Poop on accident/incontinence
- ☐ Pain or burning with peeing
- ☐ Blood in pee
- ☐ Pee on accident
- ☐ Slow starting to pee
- ☐ Frequent peeing
- ☐ Peeing at night: # of times/night _____
- ☐ Trouble getting to bathroom in time
- ☐ Painful sex
- ☐ Problems with sex
- ☐ Breast Pain
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Rash
- ☐ Hives
- ☐ Skin discoloration
- ☐ New skin concerns
- ☐ Changing skin moles
- ☐ Ulcers/Wounds
- ☐ Itching

- ☐ More Exercise or Activity Difficulty
- ☐ Shortness of Breath
- ☐ Difficulty breathing
- ☐ Chest Pain
- ☐ Wheezing
- ☐ Coughing up Blood
- ☐ Persistent Cough
- ☐ Extra sputum (saliva/mucus)

Description of sputum

_____

- ☐ Heart Palpitations
- ☐ heart flutters
- ☐ Skipped heart beats
- ☐ Can't breathe when laying flat
- ☐ Needing extra pillows
- ☐ Blue fingers or toes
- ☐ Cold fingers or toes
- ☐ Swelling in hands
- ☐ Swelling in feet
- ☐ Swelling in Legs
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Impaired Joint or spine Movement
- ☐ Joint Swelling
- ☐ Sinus pain
- ☐ Change in taste
- ☐ Lip swelling
- ☐ Tongue swelling
- ☐ Bleeding Gums
- ☐ Gum Problems
- ☐ Sore tongue
- ☐ Sore mouth
- ☐ Tooth/dental problems
- ☐ Sore throat
- ☐ Horseness, change in voice
- ☐ Neck lumps
- ☐ Neck swelling
- ☐ Problems swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Excessive burping
- ☐ Excessive farting
- ☐ Indigestion
- ☐ Heartburn/reflux
- ☐ Change in appetite
- ☐ Change in Bowel habits
- ☐ Nail problems
- ☐ Unusual hair loss
- ☐ Feeling down or sad
- ☐ Feeling hopeless
- ☐ Feeling helpless
- ☐ Feeling anxious
- ☐ Feeling edgy or figity
- ☐ Not enjoying activities
- ☐ Relationship issues
- ☐ Increased stress
- ☐ Thoughts of suicide
- ☐ Racing thoughts
- ☐ Seeing things others don't
- ☐ Hearing things others don't
- ☐ More emotional
- ☐ Mood Swings

WOMEN

- ☐ Vaginal Dryness
- ☐ Vaginal Bleeding
- ☐ Vaginal Pain
- ☐ Vaginal Itching
- ☐ Abnormal vaginal discharge

MEN

- ☐ Penis Discharge
- ☐ Penis Pain
- ☐ Penis/Teste itching
- ☐ Testicular lump
- ☐ Testicular Pain

Other Complaints: _____

Depression Screening

In the last 2 weeks, how often have you been bothered by any of the following problems? (circle the closest answer for each question)	Not at all	Several days	More than ½ the days	Nearly every day
1. Little interest of pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or 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 are 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 --- being so figety or restless that other people could have noticed?	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Anxiety Screening

In the last 2 weeks, how often have you been bothered by any of the following problems? (circle the closest answer for each question)	Not at all	Several days	More than ½ the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Lonliness Screening (De Jong Gierveld Scale)

I exerience a general sense of emptiness

☐ Yes ☐ More or less ☐ no

I miss having people around me

☐ Yes ☐ More or less ☐ no

I often feel rejected

☐ Yes ☐ More or less ☐ no

There are plenty of people I can rely on when I have problems

☐ Yes ☐ More or less ☐ no

There are many people I can trust completely

☐ Yes ☐ More or less ☐ no

There are enough people I feel close to

☐ Yes ☐ More or less ☐ no

Additional Questions For Adults 65 and Older only

FALLS RISK SCREENING: A Fall is defined as ANY unintentional change in position resulting in coming to rest on the ground or at a lower level

- ☐ I have fallen in the last year
- ☐ I have fallen in the last year and was injured
- ☐ I have fallen in the last 3 months
- ☐ I have had NO falls in the last year

If falls in the last year, how many? _____ Describe Circumstances _____

Nutrition Screening (check all that apply):

- ☐ I have an illness or condition that makes me change the kind and/or amount of foot I eat
- ☐ I eat less than 2 meals per day
- ☐ I don't eat many fruits, vegetables, or milk products
- ☐ I have 3 or more drinks of beer,liquor, or wine almost every day
- ☐ I have tooth or mouth problems that make it hard for me to eat
- ☐ I don't always have enough money to buy the food I need
- ☐ I eat alone most of the time
- ☐ I take 3 or more different prescribed or over-the-counter drugs per day
- ☐ Without wanting to, I have lost or gained 10 pounds or more in the last 6 months
- ☐ I am not always physically able to shop, cook, and/or feed myself
- ☐ NONE OF THE ABOVE APPLY TO ME

Help With Activities of Daily Living: need help with any of these? (check √ all that apply)

- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ transferring
- ☐ continence
- ☐ feeding (not food prep)

Have you or others noticed any problems or changes with your memory or cognition lately?

- ☐ yes
- ☐ no