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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner’s name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Do you have any children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Grandchildren? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pets? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Sometimes people find that their income does not quite cover their living costs. In the past 12 months, has this happened to you?

|  |  |  |  |
| --- | --- | --- | --- |
| * yes | * no | * unknown | * prefer not to answer |

If yes, what did you have trouble paying for (food, meds, clothes, utilities, gas, rent, etc.): \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Preference (men, women, both, prefer not to say): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cultural Preferences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, Interpreter Preferences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have any allergies to foods or other substances?   |  |  | | --- | --- | | * yes | * no |   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:   * 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\_\_\_\_\_\_\_\_\_\_ | Alcohol Use:   * 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? \_\_\_\_\_\_\_\_\_\_\_**

**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

**Nutrition Assessment**

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

1. Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Lunch:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Dinner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Snacks and drinks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recall foods and drinks you have on a typical day:

1. Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Lunch:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Dinner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Snacks and drinks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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, 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 \_\_\_\_\_\_\_\_\_

**Lonliness Scale (De Jong Gierveld)**

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 |

**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 |

Do you want to be checked for any sexually transmitted infections today?

|  |  |
| --- | --- |
| * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_

What do they help you manage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Specialist (area of expertise): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name/Business name: \_\_\_\_\_\_\_\_\_\_\_\_\_

What do they help you manage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Medical Hospital Stays**  (besides surgical admissions)  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **ED Visits**  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Surgeries/Procedures  Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Upcoming Procedures and timeline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Upcoming Procedures and timeline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Upcoming Procedures and timeline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Upcoming Procedures and timeline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Upcoming Procedures and timeline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Upcoming Procedures and timeline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| Last Bone/DEXA Scan:  Date \_\_\_\_\_\_\_\_\_\_\_  Results:   * Normal * Osteopenia * Osteoporosis * Unknown | If known, Last Colorectal Cancer Screenings:   * FIT Date\_\_\_\_\_ * Cologuard Date\_\_\_\_\_ * Colonoscopy Date\_\_\_\_\_\_ | Men/Assigned Male at birth:  PSA Date\_\_\_\_\_\_\_  PSA Result\_\_\_\_\_\_ | |
| Women/Assigned female at birth   |  |  |  | | --- | --- | --- | | Last Mammogram: \_\_\_\_\_\_\_  Last Period: \_\_\_\_\_\_\_\_\_\_\_\_\_ | Cervical Cancer Screening  Pap \_\_\_\_\_\_\_\_\_\_\_  HPV \_\_\_\_\_\_\_\_\_\_\_ | Total Pregnancies: \_\_\_\_\_\_\_  Total Live Births: \_\_\_\_\_\_\_\_\_  Total Miscarriages: \_\_\_\_\_\_\_\_  Total Abortions: \_\_\_\_\_\_\_\_\_\_  Total C-Sections: \_\_\_\_\_\_\_\_\_ | | | | |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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 * vitamin b deficiency * vitamin d deficiency * iron deficiency * folate deficiency * potassium problem * magnesium problem * sodium problem * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Head/Eyes/Ears/Nose/Throat   * allergy issues * sinus issues * chronic eye condition * cataracts * macular degeneration * retinopathy * dry eye syndrome * glaucoma * need or use readers * 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 * Virginal 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 * 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 | * 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 * 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 | * 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 * 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 |
| 1. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 1. 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 |
| 1. 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 |
| 1. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing | 0 | 1 | 2 | 3 |
| 1. Being so restless that it’s hard to sit still | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 1. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |