

REVIEW OF SYMPTOMS		
Please select the symptoms you have experienced recently		
GENERAL	CARDIOVASCULAR	MUSCULOSKELETAL
<input type="checkbox"/> Fever	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Chills	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Muscle pain
<input type="checkbox"/> Night sweats **	<input type="checkbox"/> Ankle or leg swelling	<input type="checkbox"/> Joint swelling <input type="checkbox"/> stiffness
<input type="checkbox"/> Feeling tired	RESPIRATORY	<input type="checkbox"/> Difficulty walking **
<input type="checkbox"/> Weight gain:	<input type="checkbox"/> Shortness of breath at rest **	INTEGUMENTARY
<input type="checkbox"/> Weight loss **	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Wounds or difficulty healing
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Cough** <input type="checkbox"/> Coughing up blood **	<input type="checkbox"/> Change in a mole
EYES	<input type="checkbox"/> Shortness of breath with activity	<input type="checkbox"/> Dry skin
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Difficulty breathing when lying flat	<input type="checkbox"/> Unusual growth
<input type="checkbox"/> Vision changes	GASTROINTESTINAL	NEUROLOGICAL
<input type="checkbox"/> Discharge from eyes	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Confusion
EARS AND NOSE	<input type="checkbox"/> Vomiting **	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Nausea **	<input type="checkbox"/> Fainting
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Constipation	<input type="checkbox"/> Recent Falls <input type="checkbox"/> in the last year**
<input type="checkbox"/> Nasal discharge	<input type="checkbox"/> Diarrhea	PSYCHIATRIC
<input type="checkbox"/> Postnasal drip	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Suicidal thoughts **
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression
THROAT	GENITOURINARY	ENDOCRINE/LYMPH
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Vocal changes	<input type="checkbox"/> Hesitancy	<input type="checkbox"/> Easy bleeding
<input type="checkbox"/> Difficulty swallowing **	<input type="checkbox"/> Wake up more than 3 times at night to urinate	<input type="checkbox"/> Easy bruising

SCREENING QUESTIONNAIRE		
Do you have a Medical Living Will?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a Healthcare Power of Attorney?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would you like more information about Advance Directives?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had a change in your smoking status?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had a change in you drinking status?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
**Do you feel safe at home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 days	Every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
<i>For office use only (Total score >3, PHQ-9)</i>				

Do you currently have:		
**Difficulty caring for yourself?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
**Changes in your ability to ambulate or walk	Yes <input type="checkbox"/>	No <input type="checkbox"/>
**Require the assistance of aids (cane, crutches, oxygen)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Since your last visit have you received any of the following: (New patient's please complete)		Date given
Influenza vaccine	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
Hepatitis A vaccine	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
Hepatitis B vaccine	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
Pneumonia vaccine : Pneumovax Pevnar 13)	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
Zosters/shingles vaccine	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
HPV	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
Colonoscopy	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
Mammogram	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	

Within the last 3 weeks if you been exposed to Chickenpox, Mumps, Measles or Rubella?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Please let your provider know if there have been any changes to your surgical, medical or family history since your last visit.

I have received a copy of my patients' rights and responsibilities.

Patient signature: _____ Date: _____

For office use only

<i>Vital Signs</i>		<i>Please verify every visit</i>	
<i>Temperature</i>		<i>Pharmacy:</i>	
<i>Pulse</i>		<i>Specialty pharmacy:</i>	
<i>Respirations</i>		<i>DME/02:</i>	
<i>Blood pressure</i>		<i>Questions for established patients:</i>	
<i>Height</i>	<i>ft in</i>	<i>Changes in allergies?</i>	
<i>Weight</i>	<i>pounds</i>	<i>Changes in medications?</i>	
<i>O2 Saturation</i>	<i>%</i>	<i>Changes in family history?</i>	
<i>Pain scale</i>	<i>/10</i>	<i>New surgeries or hospitalizations?</i>	
<i>Pain location</i>			

NOTES: