Dignity Health. Norton Thoracic Institute

Norton Thoracic Institute

Patient______________________________
Date of Birth_________________________

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

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

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
For office use only (Total score >3, PHQ-9)				

Do you currently have:		
**Difficulty caring for yourself?	Yes ☐	No ☐
**Changes in your ability to ambulate or walk	Yes ☐	No ☐
**Require the assistance of aids (cane, crutches, oxygen)	Yes ☐	No ☐

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

Within the last 3 weeks if you been exposed to Chickenpox, Mumps, Measles or Rubella?	Yes ☐ No ☐

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

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

NOTES: