Medical History Form

Have you been experiencing any of the following symptoms now or in the recent past?

Name _____ Date _____

General	No	Yes
Fever		
Chills		
Sweats/Night Sweats		
Fatigue		
Weight Gain		
Weight Loss		
HEENT		
Headaches		
Visual Changes		
Dizziness		
Nasal Discharge		
Vertigo (spinning)		
Hoarseness		
Hearing Changes		
Ear Pain		
Nose Bleed		
Ringing in the Ears		
Sore Throat		
Cardiovascular		
Chest Pain		
Shortness of Breath with exertion		
Swelling in Legs		
Palpitations		
Sudden SOB while sleeping		
Exertional Sweats		
Leg Cramps when walking		
Respiratory		
Congestion		
Shortness of Breath		
Producing Phlegm		
Cough		
Coughing up Blood		
Shortness of Breath while lying flat		
Wheezing		
Gastrointestinal		
Abdominal Pain		
Nausea/Vomiting		
Diarrhea		
Constipation		
Change in bowel habits		
Anorexia		
Rectal Bleeding		
Vomiting Blood		
Trouble Swallowing		
Reflux		

Genitourinary	No	Yes
Sudden Urge to Urinate		
Frequent Night Time Urination		
Incontinence		
Blood in Urine		
Difficulty Urinating		
Frequency of Urination		
Painful Urination		
Musculoskeletal		
Serious Joint/Bone Injuries		
Back Pain		
Joint Stiffness		
Muscle Pain		
Painful Joints		
Swollen Joints		
Hematology		
Anemia		
Prolonged Bleeding		
Recent Transfusion		
Swollen Lymph Nodes		
Skin		
Ulcers		
Psoriasis		
Blistering of Skin		
Discoloration		
Hives		
Moles		
Nodules		
Rashes		
Neurologic		
Confusion		
Weakness		
Uncoordinated Movement		
Trouble Maintaining Balance		
Difficulty Speaking		
Fainting		
Headache		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremors		
Psychiatric		
Agitation		
Disorientation		
Anxiety		
Hallucination		
Depression		
Insomnia		
Suicidal thoughts		

Tobacco history

*Do you smoke now?*_____*Ever*?____*How much*?_____*If yes, packs per day*?_____

(AUDIT C)

How often do you have a drink containing alcohol?

☐Never ☐Monthly ☐2-4 times per month ☐2-3 times a week ☐4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

☐1 or 2 ☐3 or 4 ☐5 or 6 ☐7 to 9 ☐10 or more

How often do you have six or more drinks on one occasion?

☐Never ☐Less than monthly ☐ Monthly ☐Weekly ☐Daily or almost daily

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During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Yes ☐ No Comments:

During the past 4 weeks, have you experienced bodily pain in general?

☐Yes ☐No Comments:

During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you got sick and had to stay in bed, needed some help with daily chores, or needed help just taking care of yourself?

☐Yes ☐No Comments:

In the past 7 days, did you exercise for at least 3 of them?

☐*Yes* ☐No Comments:

On days when you exercised, for how long (in minutes)?_____minutes per day

Can you get places out of walking distance without help? ☐Yes ☐No

Can you shop for groceries or clothes without help? ☐Yes ☐No

Can you prepare your own meals? ☐Yes ☐No

Can you do your own housework without help? ☐Yes ☐No

Can you handle your own money without help? ☐ Yes ☐No

Do you need help eating, bathing, dressing, or getting around your home? ☐Yes ☐No

During the past 4 weeks, would you consider yourself in good health?

☐Yes ☐ No Comments:

In the past 4 weeks, would you say things have been going well for you?

☐Yes ☐No Comments:

Are you having difficulties driving your car?

☐Yes ☐No Comments:

Do you always fasten your seatbelt when you are in a car?

☐Yes ☐No Comments:

How often during the past 4 weeks have you been bothered by any of the following problems?

Fall or dizzy when standing up	☐Yes	☐No
Sexual problems	☐*Yes*	☐No
Trouble eating well	☐Yes	☐No
Teeth or dentures	☐Yes	☐No
Hearing or problems using the telephone	☐Yes	☐No
Tired or fatigued	☐Yes	☐No

Are you taking your medications the way you were instructed to?

☐Yes ☐No Comments:

Are you confident that you can control and manage most of your health problems?

☐Yes ☐No Comments:

Is stress a problem for you in handling things such as your health, your finances, your family, social relationships, or your work?

☐Yes ☐No Comments:

In the past 2 weeks have you felt nervous, anxious, or on edge?

☐Yes ☐No Comments:

In the past 2 weeks, were you not able to stop worrying or control your worrying?

☐Yes ☐No Comments:

How many hours of sleep do you usually get?_____hours

Do you snore or has anyone told you that you snore? ☐Yes ☐No

Please choose one of the following : (Fall screening)

1. Have you fallen in the past year? ☐Yes ☐ No
2. One fall with injury in the past year? ☐Yes ☐ No
3. Two or more falls in the past year? ☐Yes ☐ No
4. One fall without injury in the past year? ☐Yes ☐ No
5. Two or more falls without injury in the past year? ☐Yes ☐ No

Have you ever had Congestive Heart Failure or water in the lungs? Yes _____ No _____
When was your last echocardiogram and where was it performed? _____

For diabetic patients only:

Have you had a retinal eye exam in the past year? Yes __ No__ If yes, by whom?_____

Please list any other current physicians and their specialty:

Physician: (ie: First, Last)	City Office is Located in:	Specialty:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or 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 the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐