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| *History and Information Forms* |  |  |
|  |  |  |
| Name: |  | Date of Birth: |  | Today’s Date: |  |
|  |  |  |  |  |  |
| ***Instructions****:**Please provide the following information before seeing your doctor—your accurate responses will help us make sure you receive the best care possible. See the front desk staff if you have any questions while completing the form.* What language are you most comfortable using to communicate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| ***Medical and Family Medical History*** |
| **Instructions:**Please identify any significant health problems or events for the following family members: |
| **Relative** | **Deceased?** | **Health Problems and/or Cause of Death***(Include age when problems started/occurred and age when relative passed away)* |
| Father | ☐ |  |
| Mother | ☐ |  |
| Siblings | ☐ |  |
| Children | ☐ |  |

**Instructions:**

 ***Preventative Screenings/ Vaccines***

Please confirm whether you have received the following preventative screenings. Please include most recent date of service, if applicable:

**Breast Cancer Screening** ­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Colorectal Cancer Screening**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEXA Scan (bone density)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Influenza Vaccine (Flu Shot)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***Hospitalizations and Emergency Room Visits*** |
| **Instructions:**Please list the names of hospitals at which you have stayed overnight and the emergency rooms you have visited during the **past 12 months**, as well as the date and the reason for your visit or stay, if applicable. |
| **Type of Visit:** | **Name of Facility** | **Date** | **Reason for Visit/Overnight Stay** |
| **ER** | **Hospital Stay** |
| ☐ | ☐ |  |  |  |
| ☐ | ☐ |  |  |  |
| ☐ | ☐ |  |  |  |
| ☐ | ☐ |  |  |  |

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| ***Providers and Specialists*** |
| **Instructions:**Please list the names of all the healthcare providers you see outside our office, including specialists (e.g., eye doctor, cardiologist, foot doctor, home health agency, etc.), if applicable. |
| **Provider Name** | **Specialty** |
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| ***Allergies*** |
| **Instructions:**Please list your allergies, their severity, and whether or not this is a new or existing allergy, if applicable. |
| **Allergy** | **Severity** | **Onset (New/Existing)** |
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| ***Medical Equipment Suppliers*** |
| **Instructions:**Please list the names of all your medical equipment supply companies (e.g., oxygen tank supplier), if applicable. |
| **Equipment** | **Name of Company** |
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| ***Medications*** |
| **Instructions:**Please list the names of all prescription medications, over-the-counter medications, vitamins, and supplements you are taking, if applicable. Please include the dose, frequency, and the pharmacy where you obtain the medication, if applicable. |
| **Medication Name** | **Dose** | **Frequency** | **Pharmacy** |
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| *Health Risk Assessment Form* | Today’s Date: |  |
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| Name: |  | Date of Birth: |  | Age: |  |
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| ***Instructions****:**Please answer the following questions before seeing your doctor. Answer the questions to the best of your ability—your accurate responses will help us make sure you receive the best care possible. See the front desk staff if you have any questions while completing the form.*  |
| 1. Gender:
 | ☐ Male | ☐ Female | ☐ Transgender | ☐ Decline to answer |  |
| 1. Race **(check all that apply)**:
 |
| ☐ White | ☐ Native American or Alaska Native |
| ☐ Black or African American | ☐ Hispanic or Latino origin or descent |
| ☐ Asian | ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Native Hawaiian or other Pacific Islander |  |
| 1. Current Marital Status:
 | ☐ Married or Remarried | ☐ Single | ☐ Divorced | ☐ Widowed |
| *If “Widowed” to #3*: Please provide when you became widowed. | \_\_\_\_\_\_\_\_\_\_\_ |
| 1. In general, how would you rate your health?
 |
| ☐ Excellent | ☐ Very good | ☐ Good | ☐ Fair | ☐ Poor |
| 1. Do you find it hard to control your bladder?
 | ☐ Yes | ☐ No |
| 1. Do you find it hard to control your bowels?
 | ☐ Yes | ☐ No |
| 1. Do you have difficulty hearing?
 | ☐ Yes | ☐ No |
| *If “Yes” to #7:* Do you wear hearing aids? | ☐ Yes | ☐ No |
| 1. Do you have difficulty with your eyes or sight/vision?
 | ☐ Yes | ☐ No |
| *If “Yes” to #8:* Do you wear glasses or contacts? | ☐ Yes | ☐ No |
| *If “Yes” to #8:* When was the last time you had a routine eye exam? | Date: \_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. In the **past four weeks**, what was the hardest physical activity you could do for **at least** 2 minutes?
 |
| ☐ Very light activity | ☐ Light activity | ☐ Moderate activity | ☐ Heavy activity | ☐ Very heavy activity |
| 1. During the **past two weeks**, has your physical and/or emotional health limited your social activities with family, friends, neighbors, or groups?
 | ☐ Yes | ☐ No |
| 1. Is stress a problem for you in handling your health, finances, family relationships, or other relationships?
 | ☐ Yes | ☐ No |
| 1. In the **past four weeks**, how often have you experienced anger?
 |
| ☐ Never | ☐ Seldom | ☐ Sometimes | ☐ Often | ☐ Always |
| 1. In the **past four weeks**, how often have you felt tired or fatigued?
 |
| ☐ Never | ☐ Seldom | ☐ Sometimes | ☐ Often | ☐ Always |
| 1. During the **past four weeks**, how much bodily pain have you generally had?
 |
| ☐ No pain | ☐ Very mild pain | ☐ Mild pain | ☐ Moderate pain | ☐ Severe pain |
| 1. Do you use tobacco products (e.g., cigarettes, chewing/dipping tobacco)?
 | ☐ Yes | ☐ No |
| *If “Yes” to #15:* Are you interested in quitting tobacco use this year? | ☐ Yes | ☐ No |
| 1. Do you exercise for about 30 minutes on five or more days per week?
 |
| ☐ Yes, most of the time | ☐ Yes, some of the time | ☐ No, I usually do not exercise this much |
| 1. Have you used drugs other than those required for medical reasons?
 | ☐ Yes | ☐ No |
| 1. Do you eat **less than** one serving of fruits and vegetables per day?
 | ☐ Yes | ☐ No |
| 1. Do you eat fast food or sugary-sweetened snacks and/or beverages more than five times per week?
 | ☐ Yes | ☐ No |
| 1. Do you have any problems with your teeth or dentures?
 | ☐ Yes | ☐ No |
| *If “Yes” to #20:* When was the last time you visited your dentist? | Date: \_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Are you sexually active?
 | ☐ Yes | ☐ No |
| 1. Do you or anyone you know have concerns about your driving abilities?
 | ☐ Yes | ☐ No |
| 1. Do you have easy access to transportation to complete daily tasks such as getting to the doctor, to the pharmacy or the grocery store?
 | ☐ Yes | ☐ No |
| 1. Do you ever drive/ride in a vehicle without wearing your seatbelt?
 | ☐ Yes | ☐ No |
| 1. Do/does furniture, rugs, cords, or poor lighting present difficulty with getting around your house?
 | ☐ Yes | ☐ No |
| 1. Are any of the stairs/steps in your home broken or uneven?
 | ☐ Yes | ☐ No |
| 1. In the **last 7 days**, did you need help from others to perform any of the following everyday activities: eating, getting dressed, grooming, bathing, walking, or using the toilet?
 | ☐ Yes | ☐ No |
| 1. In the **last 7 days**, did you need help from others to take care of any of the following activities: laundry and housekeeping, banking, shopping, food prep, transportation, or taking your own medications?
 | ☐ Yes | ☐ No |
| 1. Do you have any problems using the telephone?
 | ☐ Yes | ☐ No |
| 1. Do you have Medical Power of Attorney?

*(someone to make medical decisions for you in the event you are unable to)* | ☐ Yes | ☐ No |
| 1. Do you have a Living Will/Advanced Directive?

*(documents that make your healthcare wishes known)* | ☐ Yes | ☐ No |
| 1. Are you afraid of falling or do you feel unsteady when standing or walking?
 | ☐ Yes | ☐ No |
| 1. Have you fallen in the **last year**?
 | ☐ Yes | ☐ No |
| *If “Yes” to #33:* How many times did you fall in the **last year**?  | # Falls: \_\_\_\_\_\_ |
| *If “Yes” to #33:* Were you injured from any of your falls in the **last year**? | ☐ Yes | ☐ No |
| 1. **In a typical week**, how many drinks of wine, beer or other alcoholic beverages do you have?
 |
| ☐ None | ☐ 1 – 3 | ☐ 4 – 6 | ☐ 7 – 9 | ☐ 10+ |

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*Patient Health Questionnaire (PHQ-9)*

In the **past 2 weeks**, how often do you have these symptoms?

(Circle the answer that best matches how you feel)

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| **QUESTION** | **NOT AT ALL** | **SEVERAL DAYS** | **MORE THAN HALF THE DAYS** | **NEARLY EVERY DAY** |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 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 |
| Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| 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 |

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*Hearing Health Questionnaire*

The onset of hearing loss is usually very gradual. It may take place over 25-30 years or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Because it usually occurs slowly, you may not even be aware you have a problem until someone else brings it to your attention. Here is a simple test you can take to determine if you have a hearing problem.

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| **QUESTION** | **YES** | **NO** |
| Do others complain that you watch television with the volume too high? |  |  |
| Do you frequently have to ask others to repeat themselves? |  |  |
| Do you have difficulty understanding when in groups or in noisy situations? |  |  |
| Do you have to sit up front in meetings or in church in order to understand? |  |  |
| Do you have trouble knowing where sounds are coming from? |  |  |
| Are you unable to understand when someone talks to you from another room? |  |  |
| Have others told you that you don’t seem to hear them? |  |  |
| Do you avoid family meetings or social situations because you “can’t understand”? |  |  |
| Do you have ringing or other noises (tinnitus) in your ears? |  |  |

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*Mini-Cog™ Assessment*

Please wait until instructed to complete this assessment.