Name : ..... **DOB : .....**

Depression Screening (PHQ2):

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THANONE-HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

Wellness Profile:

Number of Falls in the last 12 months: _____
Do you have any of the following existing conditions: ☐ Anxiety ☐ Alzheimer's ☐ Dementia ☐ Depression ☐ None
Emergency room visits in the last 6 months: _____
Hospital stays in the last 6 months: _____
New vision problems: ☐ Yes ☐ No
Decreased hearing: ☐ Yes ☐ No
Do you or your family have concerns about your memory: ☐ Yes ☐ No
Overall Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check all of the activities of daily living that require assistance of any kind (human or mechanical):

☐ Ambulation/Transferring from sitting to standing
☐ Bathing/Showering
☐ Continence
☐ Dressing
☐ Feeding
☐ Finances
☐ Food Preparation
☐ Housekeeping
☐ Laundry
☐ Medication Management
☐ Shopping
☐ Toileting:
☐ Transportation

Other contributing Difficulties: ☐ None ☐ Live in an unsafe environment ☐ Lacking transportation ☐ Financial difficulty
☐ Difficulty reading or understanding instructions ☐ Lonely ☐ Frequent falls

☐ **Vaccines:**

☐ Flu Shot (one every 12 months) Date _____
☐ Pneumonia Shot (Part B covers the first shot at any time and a different, second shot if it's given at least one year after the first shot) Date _____

☐ Hepatitis B Shot Date _____
☐ Hemophilia ☐ Have ESRD
☐ Diabetic ☐ Live with someone who has

☐ **Immunizations:**

☐ TDAP _____ Date _____
☐ Shringrix _____ Date _____
☐ Pnew 23 Date _____
☐ Prevnar 13 Date _____
☐ TDAP Date _____

Males ONLY(over the age of 50):

☐ Prostate Screening (Digital Rectal Exam) Date _____
☐ Prostate Screening (bloodwork) Date _____

Females ONLY

☐ Pap Smear Date _____
☐ Mammogram Date _____

Last Colonoscopy: _____
Results: Normal Or Abnormal

Bone Scan (DEXA): _____
Results Normal Abnormal

Surgical & Hospitalization History (please list surgeries and month and year of surgery/hospitalization):

_____ _____
_____ _____
_____ _____

Family History

Do any of the following apply to your immediate `blood' relatives? Please circle

Cancer	Mom	Dad	Sis	Bro	If so, what kind: _____
Diabetes	Mom	Dad	Sis	Bro	
Heart Attack/Stroke	Mom	Dad	Sis	Bro	
High blood pressure	Mom	Dad	Sis	Bro	
Mental Health Condition	Mom	Dad	Sis	Bro	

Social History:

Tobacco (cigarettes, cigars, or chews) Use? ☐ Daily ☐ Socially ☐ Quit ☐ Never
Alcohol Use? ☐ Daily ☐ Socially ☐ Quit ☐ Never
Illicit Drug Use? ☐ Daily ☐ Socially ☐ Quit ☐ Never

If yes, please specify type used: ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Prescription ☐ Other:_____

PERSONAL Medical History: (Please check if YOU have been diagnosed with any of the following)

☐ Afib
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Fibromyalgia
☐ GERD - acid Reflux
☐ Heart Attack(s)
☐ Hepatitis
☐ Hernia
☐ High Cholesterol
☐ High Blood Pressure
☐ Osteoporosis
☐ Thyroid dysfunction
☐ Tuberculosis
☐ Ulcers

Please list all of your current providers and suppliers of healthcare

PROVIDER TPYE	PROVIDER/GROUP/CLINIC NAME	CITY & STATE
Primary Care Provider:		
Cardiologist:		
Pain Specialist:		
Pharmacy:		
Pulmonary Specialist:		
Dentist:		
Other		

Review of Symptoms (Please circle any of the following that apply to you currently or in the LAST 2 weeks):

Constitutional:

Fever,Chills , sleep issues,sweating, fatigue, weight gain or weight loss

HEENMT:

Vision loss, Blurry vision, Double vision, Eye pain, Hearing loss, Ear pain, Ringing in ears, Nosebleed, Sore throat, Swallowing issues, Voice changes.

Endocrine:

Cold intolerance, Heat Intolerance, Frequent Urination, Excessive thirst

Respiratory:

Shortness of breath at rest, Wheezing, Cough,

Cardiovascular:

Chest pain, Palpitations, leg swelling ☐

Gastrointestinal:

Abdominal pain, Change in bowel habits Diarrhea, Constipation, Blood in stool, Nausea

Hematology:

Easy Bruising, swollen glands

Genitourinary:

Difficulty urinating, Painful urination, Flank pain, incontinence, erectile dysfunction

Musculoskeletal:

New/Worsening joint pain, Extremity weakness, Muscle Aches

Skin:

Blisters, Itching, Rash, Ulcers, Changing Moles

Neurological:

Balance Difficulty,Dizziness, Difficulty speaking, Headaches, Tremor, Memory Loss

Psychiatric:

Auditory/Visual Hallucinations, Substance Abuse, Thoughts of suicide , anxiety, depression