Patient Name: _____ DOB: _____

Depression Screening (PHQ2):

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN	NOT AT ALL		MORE THANONE-HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

Wellness Profile:

Diet? ☐ Balanced ☐ Vegan ☐ High Carb ☐ Low Carb
Activity Level? ☐ None ☐ Light ☐ Moderate ☐ Vigorous
Exercise Frequency? _____ ☐ _____ x per week
Are you sexually active? ☐ Yes ☐ No

Do you have any other concerns you would like to address today?

☐ Medication Refill Needs: 30 day OR 90 Day Refill - indicate refill needs below.
☐ Weight Gain/ Loss
☐ Hormone changes
☐ Skin Changes (moles, new areas of concern)
☐ Mood changes
☐ Urinary symptoms
☐ OTHER:

Medication Refill Request:

_____

_____

_____

Current Immunizations:

Shringrix: ____ Date Received _____ Pnew 23: _____ Date Received _____
Prevnar 13 ____ Date Received _____ TDAP _____ Date Received _____

Allergies: ☐ None ☐ Latex ☐ Rubber

Medication/Allergen:	Reaction:

Surgical/ Hospitalization : (please list surgeries and year of surgery.

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Family History

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

☐ Cancer	☐ Mom ☐ Dad ☐ Sis ☐ Bro
☐ 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

GYN Intake: (Females)

LMP Start date:

Last Annual Physical:

Current Contraception Used: NONE Abstinence Birth Control Pills Condoms OTHER

Last Pap Test: Results? Normal Abnormal Unsure

Last Mammogram: Results? Normal Abnormal Unsure

Last Colonoscopy: Results? Normal Abnormal Unsure

Bone Scan(DEXA): Results? Normal Abnormal Unsure

Total Pregnancies: How Many Were Carried Full Term:

Male Intake:

Last Colonoscopy: Results? Normal Abnormal Unsure

PSA: Results? Normal Abnormal Unsure

Social History: (please circle)

Tobacco Use (Ciggarettes, cigars, or chew?) 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:

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