CPX Questionnaire

Blue Sky MD Health

Patient Name: _____ **DOB:** _____

Depression Screening (PHQ-2)

Over the past two weeks, how often have you been bothered by:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
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

☐ Skin changes (moles, new areas of concern)

☐ Urinary symptoms

☐ Hormone changes

☐ Mood changes

☐ Other: _____

Medication Refill Request:

_____

_____

_____

Current Immunizations

☐ Shingrix **Date received:** _____

☐ Prevnar 13 **Date received:** _____

☐ Pneumovax 23 **Date received:** _____

☐ TDAP **Date received:** _____

Allergies

☐ None ☐ Latex ☐ Rubber

Medication / Allergen	Reaction

Surgical / Hospitalization History

Please list surgeries and the year of each surgery.

Surgery / Hospitalization	Year

Family History

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

Condition	Mom	Dad	Sister	Brother
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart attack / stroke	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Mental health condition	☐	☐	☐	☐

GYN Intake (Females)

LMP start date: _____ **Last annual physical:** _____

Current contraception used: ☐ None ☐ Abstinence ☐ Birth control pills ☐ Condoms ☐ Other: _____

Screening	Date	Results
Last Pap test		☐ Normal ☐ Abnormal ☐ Unsure
Last mammogram		☐ Normal ☐ Abnormal ☐ Unsure
Last colonoscopy		☐ Normal ☐ Abnormal ☐ Unsure
Bone scan (DEXA)		☐ Normal ☐ Abnormal ☐ Unsure

Total pregnancies: _____ **How many were carried full term:** _____

Male Intake

Screening	Date	Results
Last colonoscopy		☐ Normal ☐ Abnormal ☐ Unsure
PSA		☐ Normal ☐ Abnormal ☐ Unsure

Social History (please circle)

Tobacco use (cigarettes, 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

Respiratory:
Shortness of breath at rest, wheezing, cough

Musculoskeletal:
New/worsening joint pain, extremity weakness, muscle aches

HEENMT:
Vision loss, blurry vision, double vision, eye pain, hearing loss, ear pain, ringing in ears, nosebleed, sore throat, swallowing issues, voice changes

Cardiovascular:
Chest pain, palpitations, leg swelling

Skin:
Blisters, itching, rash, ulcers, changing moles

Endocrine:
Cold intolerance, heat intolerance, frequent urination, excessive thirst

Gastrointestinal:
Abdominal pain, change in bowel habits, diarrhea, constipation, blood in stool, nausea

Neurological:
Balance difficulty, dizziness, difficulty speaking, headaches, tremor, memory loss

Hematology:
Easy bruising, swollen glands

Psychiatric:
Auditory/visual hallucinations, substance abuse, thoughts of suicide, anxiety, depression

Genitourinary:
Difficulty urinating, painful urination, flank pain, incontinence, erectile dysfunction