For office use only
Pt Initials: __________
DOB: ____________
DOS: ____________

Names of all providers / specialists you see:

No providers/ specialists seen outside my primary care office

Doctor's Name	Specialty/Reason you see them

List of Medical Equipment/service providers

No medical equipment utilized

Supply	Who provides this for you?
Oxygen/CPAP	
Diabetic Supplies	
Home Health	
Other	
Other	

Changes in medications since last year/visit (as compared to medication/allergy list):

No changes to report

Medication	Dose	Reason for taking

Allergy Updates (Food and/or Drug)

No changes to report

Allergy	Reaction

List any hospitalizations, major illness or visits to the emergency room since last year/visit:

None to report

Date	Reason	Location

Please review and update from current information the last time you had completed (date):

VACCINES

Influenza vaccine: ______________ COVID vaccine (1st & 2nd doses): ______________________________

Pneumonia vaccine: ____________ Tdap Vaccine: _______________ Shingles Vaccine: _________________

Hepatitis B Vaccine: ____________

Health Screening:

Overall Health Self-Assessment: Excellent Good Fair Poor Other: _________________

Have you ever smoked or chewed tobacco? yes no If yes, how much? _____________________

Do you drink alcohol? yes no If yes, how much? ____

Do you use illicit drugs? yes no If yes, what type and frequency? __________________________

Do you have new onset and/ or chronic pain? yes no

If yes, where ______________________ what type ________________ & frequency ? __________________

What type of medications do you use for pain control? NSAIDs Opioids Benzodiazepines

NSAIDs	# times/day __________	# times/week __________
Opioids	# times/day __________	# times/week __________
Benzodiazepines	# times/day __________	# times/week __________

Diet: Balanced Vegetarian Diabetic Low salt Low fat Low carb Other: ____________

Do you do some form of regular exercise every day? yes no

________ minutes per day ________ days per week _________ hours per week

Types of Exercise:

Walking Running Bicycling Swimming Aerobics Stretching/Yoga Strength Training

Other ____

Do you have trouble seeing? yes no

Do you wear glasses or contacts? yes no

Date of last vision exam with an optometrist or ophthalmologist:

Complete attached questionnaire (PHQ2 or 9) see attached form completed yes no

Do you have an Advance Directive (living will, MOST form)? yes no

OTHER ROUTINE EXAMS

Colonoscopy: ______________________________ Hemoccult: ______________________________

Bone Density Scan: _________________________

Mammogram: ____________________________ Pap Smear: ______________________________

Prostate Exam: ___________________________ PSA Test: _______________________________

Eye Glaucoma Exam: _______________________ Glucose Test: ____________________________

FOR DIABETIC PATIENTS

Foot Exam: _______________________________ HgbA1c: _________________________________

Ophthalmology Referral: ___________________ Microalbuminuria: _________________________

Accident Prevention:

Do you wear seatbelts in the car? yes no

Do you have smoke detectors at home? yes no

Do you have carbon monoxide detectors? yes no

Do you have a firearm at home? yes no If yes, is it locked up? yes no

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Optional: Office will provide you with direction for completing this page.

REVIEW OF SYMPTOMS

(Please check all that you are **currently** experiencing)

GENERAL	Fever	Chills	Recent Weight Loss or Gain	Fatigue/Tired
HEAD AND FACE	Facial Pain	Facial Pressure		
EYES	Eye Pain Red Eye	Discharge from Eye	Eye Itch Blurred Vision	Eyesight Problems
EAR NOSE THROAT (ENT)	Earache Hearing Loss	Nasal Congestion Nasal Discharge	Sneezing Sore or Scratchy Throat	Hoarseness
HEART	Pain in Chest Palpitations	Heart Rate Heart Rate Slow	Lightheadedness	Swelling of Legs
LUNGS	Shortness of Breath (SOB)	Wheezing	Cough	Coughing at Night
GASTROINTESTINAL	Abdominal Pain Abdominal Bloating/ Cramping	Menstrual Pain Nausea Vomiting	Diarrhea Constipation	Dark Stool or Blood in Stool (melena)
GENITOURINARY	Dysuria (pain while urinating) Urinary Frequency Urinary Urgency	Pelvic Pain Dark Urine Blood in Urine Nocturia (waking up at night to urinate)	Vaginal Discharge Problems with Menstrual Cycle	Abnormal Vaginal Bleeding Lumps or pain in testicles
ORTHOPEDIC	Joint/Limb Pain Muscle Aches	Back Pain Joint Swelling	Joint Stiffness Back Muscle Spasms	Swelling in Limb Limping
SKIN	Rash Lesions	Wound Itching	Mouth Sores Genital Lesions	Breast Lump Breast Pain
NEUROLOGICAL	Headache Confusion	Dizziness Fainting	Leg Numbness Tingling	Difficulty Walking Tripping/Falling
PSYCHIATRIC	Insomnia	Irritable	Anxiety Depression	Suicidal
ENDOCRINE	Hot Flashes	Night Sweats	Muscle Weakness	Generalized Weakness
BLOOD AND LYMPH	Swollen Glands	Easy Bleeding	Easy Bruising	Jaundice (yellowing of skin)
ADDITIONAL INFORMATION				

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature: ____ **Date:** ___________________________

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DOS: ________

Patient Health Questionnaire PHQ-2

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answer)	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

Social Determinants of Health Questionnaire

		YES / NO
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	
	Are you worried that in the next 2 months, you **may not have stable housing?**	
	Do problems getting **child care make it difficult for you to work** or study? (leave blank if you do not have children)	
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	
	Do you ever need help **reading hospital materials?**	
	Are you **afraid you might be hurt** in your apartment building or house?	
	Do you feel like you lack **an adequate social support system?** For example: friends, family, or community	
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	

		None 1 or more
MEN:	How many times in the past year have you had **5 or more drinks in a day?**	
WOMEN:	How many times in the past year have you had **4 or more drinks in a day?**	
ALL:	How many times in the past year have you used a **recreational drug** or used a **prescription medication for nonmedical reasons?**	

**** Not a Medicare patient? Please return this entire packet to the front office or the MA assisting you. ****

**** You are a Medicare Patient? Please continue onto the next page. ****

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Independent Activities of Daily Living

Do you require assistance with any of the following activities? (if yes is answered to any question please explain)

Eating	yes	no	________
Getting from bed to chair	yes	no	________
Dressing	yes	no	________
Bathing	yes	no	________
Toileting	yes	no	________
Continence	yes	no	________
Using the Telephone	yes	no	________
Shopping	yes	no	________
Meal Preparation	yes	no	________
Housekeeping	yes	no	________
Laundry	yes	no	________
Driving/taking taxi or bus	yes	no	________
Taking Medications	yes	no	________
Handling Finances	yes	no	________
Have you had any falls?	yes	no	________
Do you have trouble hearing?	yes	no	________
Do you wear a hearing aid?	yes	no	________
Do you wear dentures?	yes	no	________

Hearing Screen

Do people complain that you turn the TV volume too high?	yes	no
Do you find yourself asking people to repeat themselves?	yes	no
Do you have trouble hearing in a noisy background?	yes	no
Do you or your family members think that you have difficulty hearing?	yes	no

Advance Care Planning

Advance Directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to make decisions for yourself. Specifically, a Medical Durable Power of Attorney allows you to name someone to make decisions about your medical care if you can no longer speak for yourself. Another document called a Living Will (in Colorado this is sometimes called the "Declaration as to Medical Treatment") allows you to state your wishes about medical care in the event you develop a terminal condition or are in a persistent vegetative state. If you do already have these documents, it is important that you bring a copy for your chart.

Do you have a Medical Power of Attorney? If so, please bring a copy of this document for your chart.	yes	no
Do you have a Living Will (aka "Declaration as to Medical Treatment")?	yes	no
If you have completed Advance Directives, have you expressed wishes to be a DNR (Do Not Resuscitate)?	yes	no
If you have not completed Advance Directives, would like more information on how to do so?	yes	no