

Pt Initials: _____
DOB: _____
Date: _____

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

Changes will be discussed with the MA

Allergy Updates (Food and/or Drug)

No changes to report

Changes will be discussed with the MA

List any hospitalizations, major illness or visits to the emergency room since your last clinic visit.

None to report

Date	Reason	Location

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Health Screening:

Overall Health Self-Assessment: Excellent Good Fair Poor

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

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 _____

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

OTHER ROUTINE EXAMS

Colonoscopy: _____ Hemocult: _____

Bone Density Scan: _____

Mammogram: _____ Pap Smear: _____

Prostate Exam: _____ PSA Test: _____

Glucose Test: _____

FOR DIABETIC PATIENTS

Foot Exam: _____ HgbA1c: _____

Ophthalmology Referral: _____ Microalbuminuria: _____

VACCINES

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

Pneumonia vaccine: _____ Tdap Vaccine: _____ Shingles Vaccine: _____

Hepatitis B Vaccine: _____

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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
 2. Feeling down, depressed, or hopeless

Vision Screen

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: _____

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

Do you wear a hearing aid? yes no

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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	_____
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	_____
Do you wear dentures?	yes	no	_____

Bladder Risk Assessment

In the past 6 months have you experienced leaking of urine? _____

During the past 6 months, has leaking of urine caused you to make changes to your daily activities or interfered with your sleep? _____

Fall Risk Assessment

Have you fallen in the past 12 months? _____

If so, did the fall result in injury? yes no **Type of injury** _____

In the past 12 months, have you had a problem with balance or walking? _____












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

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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?	