DEMOGRAPHICS

NAME: _____

Date of Birth: _____ **Age**:_____ **Gender**: _____

Date of Last Wellness Visit: _____ **Location / Provider Name:** _____

INFECTIOUS DISEASE RISK SCREEN

Recent travel history within the last 2 months.

Recent Travel History	None	Yes	
		Date	Location
Self	◯		
Family Member / Household / Contact Travel History	◯		

COVID-19 Screening – *select one of the following.*

◯ None	◯ Community exposure to COVID-19 within the last 14 days	◯ COVID-19 Symptoms Present	◯ Exposure to respiratory illness of unknown etiology	◯ Healthcare exposure to COVID-19 within the last 14 days

HEALTH STATUS (CARE PROVIDERS)

Other Doctors

Other than your Primary Care Provider, what other doctors provide care for you? Please list below.
PROVIDER NAME, SPECIALTY, AND REASON

_____

_____

_____

_____

Other Medical Services (Ancillary Services)

What other medical services do you use? Please list below.

NAME, SERVICE, CONTACT INFORMATION, LOCATION, COMMENTS.

SERVICE EXAMPLES: Audiologist, Bath Aid, Dietetics, Home Health, Meals on Wheels, Pharmacy, Therapy: (Physical, Occupational, Respiratory, Speech), Social Services.

Medical Devices

Do you have any of the medical devices listed below?

- ◯ None
- ◯ Implantable cardioverter-defibrillator
- ◯ Insulin Pump
- ◯ Medication Pump
- ◯ Pacemaker
- ◯ Other: _____

Medical Equipment

Do you have any of the following medical equipment?

- ◯ None
- ◯ Oxygen therapy
- ◯ Walker
- ◯ Wheelchair
- ◯ Bed
- ◯ Commode
- ◯ CPAP
- ◯ Spirometry
- ◯ Splint
- ◯ Immobilizer
- ◯ Other: _____

Have you been hospitalized since your <u>last visit</u> (*circle one*)? YES or NO. *If yes, continue.*

	Were you in the Hospital?		Were you in the ER?	
	◯ Yes	◯ No	◯ Yes	◯ No
Date of Discharge				
Date of Follow-up Visit				
Was a Discharge Plan Provided?	◯ Yes	◯ No	◯ Yes	◯ No
Were your hospital medications reconciled with your current meds?	◯ Yes	◯ No	◯ Yes	◯ No

CHRONIC PROBLEMS & ILLNESSES

List any ongoing or chronic medical problems or illnesses:

PROCEDURE HISTORY

List history of surgeries and hospitalizations with approximate date:

ALLERGIES AND MEDICATIONS

ALLERGIES

List any medication allergies and the reaction that you have to that medication:

MEDICATIONS

Please list all medications including over the counter supplements you are currently taking.

Name of Medication	Strength	Direction	Prescribed by

FAMILY HISTORY

	Living or Deceased	Current Age or Age at Death	Medical Problems during lifetime and cause of death, if applicable to person.
Father			
Mother			
Brother(s)			
Sister(s)			
Father's father			
Father's mother			
Mother's father			
Mother's mother			
Other Notable Family Members			

SOCIAL HISTORY

Do you smoke tobacco (*circle one*)? **YES or NO**

If yes, about how many/day? _____

Do you feel you need to change this habit? YES or NO

Any concerns about tobacco use in your household? YES or NO

Have you ever used electronic cigarettes/vaping? (*circle one*)? **YES or NO**

If yes, current status? _____

Do you feel you need to change this habit? YES or NO

Passive exposure? YES or NO

Do you drink alcohol (*circle one*)? **YES or NO**

If yes, about how many drinks per week? 0-3 3 or more

If 3 or more drinks per week, how many per day? 0-2 2-5 5 or more

What is your favored drink type? Beer Wine Liquor Other: _____

Do you feel you need to change this habit (*circle one*)? **YES or NO**

Do you use other substances such as marijuana or other drugs (*circle one*)? **YES or NO**

If yes, about how many times? Per week _____ Per day _____

Nutritional History

What type of diet do you adhere to?

- ◯ Unrestricted/normal
- ◯ Calorie restricted
- ◯ Vegetarian
- ◯ Kosher
- ◯ Diabetic
- ◯ Renal
- ◯ Other(such as sodium restricted): _____

Exercise History

How many days do you exercise each week? 0-2 2-4 4-6 6+

Circle the average number of minutes you exercise in a day: 0-15 15-30 30-45 45-60 60+

What types of exercise do you prefer?

◯ Aerobics ◯ Bicycling ◯ Organized team sports ◯ Running ◯ Swimming

◯ Walking ◯ Weight lifting ◯ Yoga ◯ Other: _____

From your point of view what condition are you in?

◯ Poor ◯ Fair ◯ Good ◯ Excellent

DEPRESSION SCREENING

How many days in the last two weeks have you been bothered by the below symptoms?

Little Interest, Pleasure in Activities	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All
Feeling Down, Depressed, Hopeless	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All

Please continue on to the following questions, ***if you chose an option other than "not at all"*** *from the questions above. If you have chosen "not at all" to both questions, you may skip to the next section.*

How many days in the last two weeks have you been bothered by the below symptoms?

Trouble Falling or Staying Asleep	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All
Feeling Tired or Little Energy	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All
Poor Appetite or Overeating	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All
Feeling Bad about Yourself	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All
Trouble Concentrating	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All
Moving or Speaking Slowly	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All
Thoughts about Hurting Yourself **	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All

****IMPORTANT: If you responded Several, Half or More, or Nearly All to this question complete the section titled SUICIDE RISK SCREEN.**

Difficulty at Work, Home, or Getting Along with Others	◯ Not at all	◯ Several	◯ Half or More	◯ Nearly All

SUICIDE RISK SCREEN

Please answer these questions if you responded Several, Half or more, or Nearly all to ***the Thoughts about Hurting Self*** question within the Depression Screening.

1)	In past month, have you wished you were dead or wished you could go to sleep and not wake up?	◯ Past month, yes	◯ Past month, no
2)	In the past month, have you actually had thoughts about killing yourself?	◯ Yes	◯ No

If you answered yes to question 2, please complete questions 3-5. If you answered no to question 2, please skip to question 6.

3)	In the past month, have you been thinking about how you might kill yourself?	◯ Yes	◯ No
4)	In the past month, have you had these thoughts and had some intention of acting on them?	◯ Yes	◯ No
5)	In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	◯ Yes	◯ No
6)	Have you ever done anything, started to do anything, or prepared to do anything to end your life?	◯ Yes	◯ No

If you answered yes to question 6, please answer question 7.

7)	In the past 3 months, have you done anything, started to do anything, or prepared to do anything to end your life?	◯ Yes	◯ No

HEARING AND VISION

1)	Do you wear corrective lenses? (Glasses or contacts)?	YES	or	NO
2)	Do you have difficulty with your hearing?	YES	or	NO

HOME SAFETY

1)	Are emergency numbers kept by the phone and regularly updated?	YES	or	NO
2)	Are all household members aware of the dangers of smoking, especially in bed?	YES	or	NO
3)	Are working smoke alarms and fire extinguishers available for use?	YES	or	NO
4)	Do all household members know how to use them?	YES	or	NO
5)	Are all firearms stored unloaded and securely locked?	YES	or	NO
6)	Have rugs been removed or fastened down?	YES	or	NO

7) Are non-slip mats in all bathtubs and showers? YES or NO

8) Do all stairways have a railing or banister? YES or NO

9) Are sidewalks and all other steps clear of tools, toys, and other articles? YES or NO

10) Are doorways, halls, and stairs free of clutter? YES or NO

11) Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails? YES or NO

FUNCTIONAL ASSESSMENT

Check the box which indicates who completes these tasks for you.

Bathing or Showering	◯ Self	◯ Some help from others	◯ Others
Dressing	◯ Self	◯ Some help from others	◯ Others
Transferring to bed or chair	◯ Self	◯ Some help from others	◯ Others
Using the Restroom	◯ Self	◯ Some help from others	◯ Others
Eating Meals	◯ Self	◯ Some help from others	◯ Others

FUTURE PLANNING

Do you have an advance directive? YES or NO

If yes, does PSMC have a copy of it? YES or NO

If no, please provide a copy to PSMC for our records.

If you do not have an advance directive, do you wish to receive further information? YES or NO

IMMUNIZATIONS

Have you received a Covid-19 vaccination?

- ◯ Yes, series started
- ◯ Yes, series completed
- ◯ No
- ◯ Declined

STABILITY SCREEN

Have you fallen in the past year?	YES	or	NO
How many times?	0	1	2+
Were you injured?	YES	or	NO
Do you feel unsteady standing or walking?	YES	or	NO
Do you worry about falling?	YES	or	NO

OPIOID RISK

Respond to these questions based on **family** history.

1) Do you have a family member with a history of substance abuse? *Select male and/or female as appropriate for each item.*

	Was the family member female?	**Was the family member male?**
Alcohol	◯	◯
Illegal Drugs	◯	◯
Prescription	◯	◯

Respond to these questions based on your **personal** history.

2) Do you have a history of substance abuse? *If yes, mark under the column for your gender.*

	Are you a female?	**Are you a male?**
Alcohol	◯	◯
Illegal Drugs	◯	◯
Prescription	◯	◯

3) Are you between 16 – 45 years of age? YES or NO

4) Do you have a history of Preadolescent Sexual Abuse? YES or NO

5) Psychological Disease? YES or NO

Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia

6) Depression? YES or NO

PAIN ASSESSMENT

If you have pain, please complete the following:

Pain location: _____

Is the pain?	What is the quality of the pain?		Time pattern:	What is your pain score?
◯ Bilateral	◯ Aching	◯ Sharp	◯ Acute	*Scale code:*
◯ Left	◯ Burning	◯ Stabbing	◯ Chronic	**0** = no pain
◯ Right	◯ Cramping	◯ Tender	◯ Constant	**5** = moderate pain
				10 = worst possible pain
◯ Midline	◯ Discomfort	◯ Other _____	◯ Intermittent	*Select one.* 0 1 2 3 4 5 6 7 8 9 10

HEALTH MAINTENANCE

Please record when you last received or completed the following items. If never or not applicable, write N/A.

Hepatitis B	_____	Hearing Exam	_____
Flu Vaccine	_____	Alcohol Cessation	_____
Pneumonia Vaccine	_____	Smoking Cessation	_____
Tetanus Vaccine	_____	Nutrition Therapy	_____
Shingles Vaccine	_____	Diabetic Education	_____
Glucose	_____	A1c (Diabetic Only)	_____
Aneurysm Screen	_____	Mammogram (Female)	_____
Bone Density Scan	_____	Pap Smear (Female)	_____
Colonoscopy	_____	Pelvic Exam (Female)	_____
Lipid Panel	_____	Prostate Exam (Male)	_____
Eye Exam	_____	PSA Test (Male)	_____
Echocardiogram	_____	Rectal Exam (Male)	_____