Birth Date: __ __ - __ __ - __ __ __ __ MM-DD-YYYY **MRN:**

Last Name:

Past Medical History

	Year of onset		Year of onset		Year of onset
☐ Allergies		☐ Depression		☐ Irritable bowel disease	
☐ Anemia		☐ Diabetes, Type I		☐ Liver disease	
☐ Angina		☐ Diabetes, Type II		☐ Migraine headaches	
☐ Anxiety		☐ GERD/Reflux		☐ Myocardial infarction	
☐ Arthritis		☐ Gallbladder disease		☐ Osteoporosis	
☐ Asthma		☐ Heart disease		☐ Kidney disease	
☐ Benign prostatic hypertrophy		☐ High blood pressure		☐ Seizure disorder	
☐ Blood clots		☐ High cholesterol		☐ Stroke	
☐ COPD		☐ Irregular and rapid heart rate		☐ Thyroid disease	
☐ Coronary artery disease		☐ Irregular heart rate			

☐ Cancer Type: ________ Type: ________

Are there any other medical problems we should know about?

Past Surgical History

	Year		Year		Year
☐ Angioplasty		☐ Coronary Artery Bypass Graft		☐ Surgical repair of broken bone	
☐ Appendectomy		☐ Gallbladder removal		☐ Pacemaker	
☐ Arthroscopic knee		☐ Gastric bypass		☐ Removal of all or part of colon	
☐ Blood transfusion		☐ Hernia repair		☐ Thyroid removal	
☐ Carpal tunnel release		☐ Hip replacement		☐ Tonsil removal	
☐ Cataract removal		☐ Knee replacement			
☐ Colostomy		☐ LASIK			

☐ Back Surgery Type: ________

Are there any other surgeries we should know about?

Family History

☐ Adopted - no family history known

	Mother	Father	Sister(s)	Brother(s)
	Yes	*Yes*	*Yes*	*Yes*
Alive and Well	☐	☐		
Deceased	☐	☐		

Check "Yes" if the indicated family member has any of the following diseases. Also indicate if it were their cause of death *(COD)*.

ADD/ADHD	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Alzheimer's disease	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Coronary artery disease	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Type:		Type:	Type:	Type:
CVA (stroke)	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Developmental delay	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Genetic Disease	☐	☐	☐	☐
Type:		Type:	Type:	Type:
Hearing Deficiency	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Irritable bowel syndrome	☐	☐	☐	☐
Learning disability	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Peripheral vascular disease	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐
Thyroid disorder	☐	☐	☐	☐
Other	☐	☐	☐	☐

Social History

Tobacco use:

Have you ever used tobacco? ☐ No/Never ☐ Yes ☐ Unknown

Please check any of the below that you have ever used:		Use daily?	Amount per day:	Number of Years:	Age started:	Age stopped:
☐	Cigarettes	☐	Packs			
☐	Cigarillos	☐	Cigarillos			
☐	Cigar	☐	Cigars			
☐	Pipe	☐	Pipes			
☐	Chewing	☐	Ounces			
☐	Snuff	☐	Ounces			
☐	Smokeless (Electronic)	☐	Units			

If you are a current smoker, have you ever tried to quit using tobacco? ☐ Yes ☐ No ☐ Unknown

If yes, *tobacco type* is required:

What *tobacco type* did you try to quit using? Select 1

☐ Cigarettes ☐ Cigarillos ☐ Cigar ☐ Pipe

☐ Chewing ☐ Snuff ☐ Smokeless (Electronic)

How long were you tobacco free?

☐ Day(s) ☐ Week(s)

☐ Month(s) ☐ Year(s)

Is there second hand smoke exposure? ☐ Yes ☐ No

Vaping Use:

Vaping Status: ☐ Current user ☐ Not a current user ☐ Not Documented

Do you vape without Nicotine? ☐ Yes

At what aged did you start vaping? ☐☐ At what age did you stop vaping? ☐☐

Statuses

Hand dominance ☐ Left ☐ Right ☐ Ambidextrous

Do you or have you served in the Military? ☐ Yes ☐ No

Alcohol/Caffeine

Drinks alcohol:

☐ No, skip to Drinks caffeine.

☐ Formerly If formerly, year quit: ☐☐☐☐

☐ Yes, please answer the below questions:

Type: Amount:

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Last drink: ☐ today ☐ yesterday ☐ two weeks ago ☐ one year ago

☐ last night ☐ last week ☐ last month Other:

If you are a male patient under 65 years of age, how many times in the past year have you had 5 or more drinks in a day? Or, if you are a male patient 65 years of age and older or a female patient, how many times in the past year have you had 4 or more drinks in a day? ☐☐☐

330.2006.23.5

Drinks caffeine:

☐ No, skip to Lifestyle

☐ Yes, please answer the below questions:

Type (select up to 2)

☐ chocolate ☐ energy drinks ☐ tablets

☐ coffee ☐ soda ☐ tea

Other:

Amount of Caffeine per day

☐☐ ☐ cups ☐ ounces

Lifestyle

Have you traveled out of the country recently? ☐ Yes ☐ No

What is your activity level? ☐ Moderate ☐ Sedentary ☐ Vigorous

Have you had any falls in the last year? ☐ Yes ☐ No

If yes, how many? ☐☐ Did the fall(s) result in injury? ☐ Yes ☐ No

For staff use only:

Tobacco cessation discussed: ☐ Yes

Select all that apply:

☐ Other (non-meaningful use) ☐ Referral to stop-smoking clinic ☐ Smoking effects education

☐ Pregnancy smoking education ☐ Smoking cessation education

Vaping cessation discussed: ☐ Yes ☐ No

Comments:

Alcoholism counseling: ☐ Yes Time in counseling (5-15 minutes) ☐☐

Falls risk: Is the patient at risk for falls? ☐ No ☐ Yes

Patient Name: Appt Date:

Review of Symptoms

Are you currently experiencing any of the following symptoms?

Constitutional Symptoms

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Weight Gain

HEENT

- ☐ Visual Changes
- ☐ Vision Loss
- ☐ Blurred Vision
- ☐ Dental Cavities
- ☐ Double Vision
- ☐ Dry Mouth
- ☐ Dry Eyes
- ☐ Trouble Swallowing
- ☐ Nose Bleeds
- ☐ Eye Pain
- ☐ Facial Pain
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Jaw Pain
- ☐ Nasal Drainage
- ☐ Nasal Sores
- ☐ Oral Ulcers
- ☐ Red Eye
- ☐ Sinusitis
- ☐ Sore Throat
- ☐ Ringing in Ears

Respiratory

- ☐ Stop Breathing at Night
- ☐ Cough
- ☐ Frequent URI
- ☐ Coughing up Blood
- ☐ SOB When lying flat
- ☐ SOB/Coughing at night

Respiratory

- ☐ Pleuritic Pain
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular

- ☐ Chest Pain
- ☐ Claudication
- ☐ Edema
- ☐ Palpitations
- ☐ Raynaud's
- ☐ Substernal Chest Pain
- ☐ Tachycardia
- ☐ Blood Clots
- ☐ Varicose Veins

Gastrointestinal

- ☐ Abdominal Cramping
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Trouble Swallowing
- ☐ Early Satiety
- ☐ Stomach Pain
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

Genitourinary

- ☐ Buring Urination
- ☐ Genital Lesions
- ☐ Genital Ulcers
- ☐ Hematuria
- ☐ Impotence
- ☐ Kidney Stones

Genitourinary

- ☐ Urinating Frequently at Night
- ☐ Pelvic Pain
- ☐ Excessive Urination
- ☐ Recurrent UTI
- ☐ Urinary Frequency
- ☐ Urinary Incontinence

Metabolic/Endocrine

- ☐ Cold Intolerance
- ☐ Breast Enlargement
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Excessive Hair
- ☐ Hot Flashes
- ☐ Polydipsia (incr.thrist

Neurologic

- ☐ Confusion/Disorientation
- ☐ Dizziness
- ☐ Extremity Numbness
- ☐ Extremity Weakness
- ☐ Gait Disurbance
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Syncope (Fainting)
- ☐ Tingling
- ☐ Tremors

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Emotionally Libile
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Suicidal Ideation

Immunologic

- ☐ Allergic Rhinitis
- ☐ Frequent Infections
- ☐ Food Allergies

Integumentary

- ☐ Acne
- ☐ Brusing
- ☐ Discoid Rash
- ☐ Hives
- ☐ Itching
- ☐ Nail Changes
- ☐ Photosensitivity
- ☐ Psoriasis
- ☐ Rash
- ☐ Scalp Tenderness
- ☐ Skin Lesion

Musculoskeletal

- ☐ Back Pain
- ☐ Height Loss
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Tenderness
- ☐ Low Back Pain
- ☐ Morning Stiffness
- ☐ Muscle Cramping
- ☐ Muscle Weakness
- ☐ Muscular Atrophy
- ☐ Myalgia
- ☐ Neck Pain
- ☐ Neck Stiffness

Hematologic/Lymph

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes

Appt Date:

Patient Name:

Birth Date: **Gender:**

Rendering Provider: **MRN:**

This questionnaire includes information not available from blood test, x-ray, or any other source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can by yourself, if you need help, please ask. There are no right or wrong answers. Please answer exactly as you feel. Thank you.

1. Please place a (x) in the ONE best answer for your abilities at this time:

Over the last week, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** to do
a. Dress yourself, include tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
b. Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
c. Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
d. Walk outdoors on flat grass?	☐ 0	☐ 1	☐ 2	☐ 3
e. Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
f. Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
g. Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
h. Get in or out car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
i. Walk two miles or three kilometers if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
j. Participate in recreational activities and sports as you would like,if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
k. Get a good nights sleep?	☐ 0	☐ 1	☐ 2	☐ 3
l. Deal with feeling of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
m. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition OVER THE PAST ONE WEEK? Please indicate below how severe you pain has been:

NO PAIN ☐ 0 ☐ .5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5 ☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 7 ☐ 7.5 ☐ 8 ☐ 8.5 ☐ 9 ☐ 9.5 ☐ 10 PAIN AS BAD AS IT COULD BE

3. Please check the appropriate spot to indicate the amount of pain you are having TODAY in each of the joint areas listed below:

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
NECK	☐ 0	☐ 1	☐ 2	☐ 3	LUMBAR	☐ 0	☐ 1	☐ 2	☐ 3

4. Consider all the ways in which illness and health conditions may effect you at this time, please indicate how you are doing:

Very Well ☐ 0 ☐ .5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5 ☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 7 ☐ 7.5 ☐ 8 ☐ 8.5 ☐ 9 ☐ 9.5 ☐ 10 Very Poorly

330.2006.23.7

Birth Date: ☐☐ - ☐☐ - ☐☐☐☐ MM-DD-YYYY **MRN:** ☐☐☐☐☐☐☐☐☐☐☐☐

Last Name:

Medications

Please list below all drugs and medications taken over the last week(including birth control pills, aspirin and any kind of drug or medication bought without a prescription.)

Name of Drug or Medicine	Dosage If Known	How Many Per Day	How Helpful is it (A lot)	(Some)	(None)	Any side Effects (Yes)	(No)	If Yes was it (GI)	(Skin)	(Other)
1			☐	☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐	☐	☐	☐	☐
5			☐	☐	☐	☐	☐	☐	☐	☐
6			☐	☐	☐	☐	☐	☐	☐	☐
7			☐	☐	☐	☐	☐	☐	☐	☐
8			☐	☐	☐	☐	☐	☐	☐	☐
9			☐	☐	☐	☐	☐	☐	☐	☐
10			☐	☐	☐	☐	☐	☐	☐	☐
11			☐	☐	☐	☐	☐	☐	☐	☐
12			☐	☐	☐	☐	☐	☐	☐	☐
13			☐	☐	☐	☐	☐	☐	☐	☐
14			☐	☐	☐	☐	☐	☐	☐	☐
15			☐	☐	☐	☐	☐	☐	☐	☐
16			☐	☐	☐	☐	☐	☐	☐	☐
17			☐	☐	☐	☐	☐	☐	☐	☐

Sign:______________________________ Date:__________________