

NEW PATIENT ADULT COMPREHENSIVE HEALTH ASSESSMENT - LARGE PRINT

Please answer these questions to help us maintain accurate records and provide high quality care. All information will be kept confidential. Please discuss any questions about these items with your doctor or clinical staff.

Patient Name:

DOB:

Do you have a living will, advance directive or DNR? Yes No

Do you have any special hearing needs? Yes No Do you have vision impairment? Yes No

Preferred Pharmacy

Name:

Location:

Number:

Medications

Please list all your MEDICATIONS (prescriptions, over the counter, vitamins, herbal supplements). Include the dose and frequency for each.

<u>Drug Name</u>	<u>Dosage</u>	<u>Drug Name</u>	<u>Dosage</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Do you have any allergies to medications, foods, or other substances? If yes, please list each and the reaction you've experienced.

<u>Allergic to</u>	<u>Reaction</u>	<u>Allergic to</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____

Chronic Conditions / Past Medical History

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Urinary Tract Infection / UTI | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> COPD/ Emphysema/ Bronchitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Gastrointestinal Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Diverticulitis or Diverticulosis |
| <input type="checkbox"/> Heart Attack / MI | <input type="checkbox"/> Tuberculosis / TB | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heartburn / Reflux Problems |
| <input type="checkbox"/> Heart Failure / CHF | <input type="checkbox"/> Sexually Transmitted Infection | <input type="checkbox"/> Allergies / Hay Fever | <input type="checkbox"/> Arthritis / Joint Problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other Sexual Problems | <input type="checkbox"/> Blood or Bleeding Disorders | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Problems |
| <input type="checkbox"/> Cancer (Please list type below) | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Hepatic / Liver Disease | <input type="checkbox"/> Alcohol Problems |
| | | | <input type="checkbox"/> Other (Please explain below) |

Cancer:

Other:

Surgical History

Please list all OPERATIONS you have had and give the approximate DATE of each:

<u>Operation</u>	<u>Date</u>	<u>Operation</u>	<u>Date</u>
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Joint surgery	_____
<input type="checkbox"/> Cholecystectomy (gallbladder out)	_____	_____	_____
<input type="checkbox"/> Hysterectomy	_____	_____	_____
<input type="checkbox"/> Heart surgery	_____	_____	_____

Hospitalizations

Please list the diagnosis/reason for all HOSPITALIZATIONS you have had and give the approximate DATE of each:

<u>Diagnosis/Reason</u>	<u>Date</u>	<u>Diagnosis/Reason</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____

NEW PATIENT ADULT COMPREHENSIVE HEALTH ASSESSMENT - LARGE PRINT

Patient Name:

DOB:

Diagnostic Studies (for example: stress tests, echocardiograms, CAT scans, MRIs)

Please list all DIAGNOSTIC STUDIES you have had and give the approximate DATE of each:

<u>Study</u>	<u>Date</u>	<u>Study</u>	<u>Date</u>
<input type="checkbox"/> Heart Stress Test	_____	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____	_____
<input type="checkbox"/> Heart Catheterization	_____	_____	_____
_____	_____	_____	_____

Family History

Has anyone in your IMMEDIATE family had any of the following illnesses?

<u>Illness</u>	<u>Family Member / Age Diagnosed</u>	<u>Illness</u>	<u>Family Member / Age Diagnosed</u>
Cancer (list type)	_____	Suicide / Suicide Attempt	_____
High Blood Pressure	_____	Asthma	_____
High Cholesterol	_____	Osteoporosis / Thinning Bones	_____
Diabetes	_____	Glaucoma	_____
Heart Attack / MI	_____	Kidney Disease	_____
Stroke or Mini-Stroke / TIA	_____	Bleeding Disorder	_____
Depression / Bipolar	_____	Genetic Disorder	_____
Drug/Alcohol Problems	_____	Other (list type)	_____

Is your mother alive? Yes No If not, age at death and cause of death: _____

Is your father alive? Yes No If not, age at death and cause of death: _____

Social / Occupational History

Present Occupation? _____

Previous Occupation? _____

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? If so, which ones?

Have you ever been exposed to any environmental hazards such as radiation, toxic waste, or lead paint? If so, which ones?

Lifestyle / Safety

Do you use tobacco products? Yes No If yes, what kind? _____ How much? _____

Do you drink alcohol? Yes No If yes, what kind? _____ How much per week? _____

Do you drink caffeine? Yes No If yes, what type / how much? coffee tea soda _____

Do you exercise? Yes No If yes, what type / how much? cardio weights swim _____

Do you follow a particular diet? Yes No low fat low salt low carbohydrate

vegetarian vegan gluten-free

Do you have smoke detectors? Yes No

Do you have a gun in your house? Yes No If yes, is it under lock and key? _____

Do you wear a seatbelt? Yes No

Have you travelled outside the U.S.? Yes No If yes, where? _____

Answering the following questions will help us provide the best possible care. Your answers will be confidential.

Do you use drugs? (Cocaine, marijuana, opiates, etc.) Yes No If yes, what type? _____

Have you been sexually active? Yes No If yes, with men women both

How many sexual partners have you had? currently _____ lifetime _____

Do you practice safe sex? Yes No If yes, what method of protection do you use? _____

Do you use condoms? Yes No If yes, how often do you use them? Always Sometimes

Do you use other contraception? Yes No If yes, what? birth control pills IUD sponge
 diaphragm rhythm method

NEW PATIENT ADULT COMPREHENSIVE HEALTH ASSESSMENT - LARGE PRINT

Patient Name:

DOB:

Health Maintenance

When was your LAST (Please give approximate date):

Pap Smear _____	Prostate Exam / PSA _____
Breast Exam _____	Stool Check for Blood _____
Mammogram _____	Colonoscopy Exam _____
DEXA Scan _____	Cholesterol Check _____
	Complete Physical _____

Immunizations

Have you had any of these IMMUNIZATIONS?

Influenza/Flu _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____	Hepatitis B _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____
Tetanus/Td alone _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____	HPV/Cervical Cancer _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____
Tetanus with Pertussis/Tdap _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____	Zoster/Shingles _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____
Pneumonia/Pneumovax _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____	Meningococcal _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____

Patient Health Questionnaire (PHQ-2): Please circle your response.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	<u>Not at All</u>	<u>Several Days</u>	<u>More Than Half the Days</u>	<u>Nearly Every Day</u>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3