Full Name ____ Birth Date ____________________

Reason for visit

Chronic Condition	Did you bring your log	Did you bring your medication	New problems
Diabetes			
Hypertension			

Problem	How long	What makes it worse	What makes it better

Pain Level Today	1	2	3	4	5	6	7	8	9	10

Allergies

Medications: The Nurse will ask please have the bottles or names ready

Recent Visits Hospital, ER, Prompt Care, any other providers

Visit	Why were you seen	Any changes to medications

Have you had a fall in the past year	Yes	No
Are you having trouble getting to the bathroom in time	Yes	No

Do you currently	Yes	Former	How often	Do you feel you need to stop or decrease your use	Have you been told you should stop or decrease your use
Use Tobacco products					
Drink alcohol					
Have a substance abuse problem					

Patient Health Questionnaire – In the past 2 weeks how often have you felt	Not at All	Less than 1 week	More than 1 week	Every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

When was your last? (If you are a returning patient, list any that have been done since last visit)

Labs	
Pap	
Mammogram	
Bone Density	
Colonoscopy	
Eye Exam	
Dental Exam	
Flu Vaccine	
Pneumonia 23 vaccine	

Pneumonia 13 vaccine	
Tetanus /Booster	
HPV vaccine	
Hepatitis B vaccine	
Shingles/Zoster vaccine	
COVID vaccine	

Full Name ____ Birth Date ______________________

Medical History

Diagnosis	Yes	Are you on medication for this
Alcoholism/Drug Abuse		
Allergies		
Anemia		
Arthritis		
Asthma		
Blood Clot		
Cancer		
Congestive Heart Failure		
Dementia/Memory loss		
Depression/Anxiety/Bipolar/ Schizophrenia		
Diabetes		
Emphysema/COPD		

Diagnosis	Yes	Are you on medication for this
Gout		
Heartburn		
Heart Disease		
Hepatitis		
HIV		
Hypertension		
High Cholesterol		
Kidney Disease		
Liver Disease		
Lupus/Rheumatoid Arthritis		
Migraine		
Seizure Disorder		
Sleep Apnea		
Stroke		

Family History

Please check	Diabetes	High Blood Pressure	Heart Disease	Kidney Disease	Thyroid Disorder	Clotting Disorder	Cancer	Mental Health Disorder	Substance Abuse
Mother									
Father									
Sister									
Brother									
Children									
Mother’s Mom									
Mother’s Dad									
Father’s Mom									
Father’s Dad									
Other									

Surgical History Aa

Appendectomy	
Breast Biopsy/Surgery	
Tubal ligation	
Cardiac Bypass	
Gall Bladder Removal	
Hernia Repair	
Hysterectomy	
Joint Surgery/Replacement	