

Medical History Form

Have you had any of the following symptoms since your last visit?

Name _____

Date _____



General	No	Yes
Fever		
Chills		
Sweats/Night Sweats		
Fatigue		
Weight Gain		
Weight Loss		
HEENT		
Headaches		
Visual Changes		
Dizziness		
Nasal Discharge		
Vertigo (spinning)		
Hoarseness		
Hearing Changes		
Ear Pain		
Nose Bleed		
Ringing in the Ears		
Sore Throat		
Cardiovascular		
Chest Pain		
Shortness of Breath with exertion		
Swelling in Legs		
Palpitations		
Sudden SOB while sleeping		
Exertional Sweats		
Leg Cramps when walking		
Respiratory		
Congestion		
Shortness of Breath		
Expectoration		
Cough		
Coughing up Blood		
Shortness of Breath while lying flat		
Wheezing		
Gastrointestinal		
Abdominal Pain		
Nausea/Vomiting		
Diarrhea		
Constipation		
Change in bowel habits		
Anorexia		
Rectal Bleeding		
Vomiting Blood		
Trouble Swallowing		
Reflux		

Genitourinary	No	Yes
Sudden Urge to Urinate		
Frequent Night Time Urination		
Incontinence		
Blood in Urine		
Difficulty Urinating		
Frequency of Urination		
Painful Urination		
Musculoskeletal		
Serious Joint/Bone Injuries		
Back Pain		
Joint Stiffness		
Muscle Pain		
Painful Joints		
Swollen Joints		
Hematology		
Anemia		
Prolonged Bleeding		
Recent Transfusion		
Swollen Lymph Nodes		
Skin		
Ulcers		
Psoriasis		
Blistering of Skin		
Discoloration		
Hives		
Moles		
Nodules		
Rashes		
Neurologic		
Confusion		
Weakness		
Uncoordinated Movement		
Unbalanced		
Difficulty Speaking		
Fainting		
Headache		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremors		
Psychiatric		
Agitation		
Disorientation		
Anxiety		
Hallucination		
Depression		
Insomnia		
Suicidal thoughts		

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- a. Never
- b. Monthly or less
- c. 2-4 times a month
- d. 2-3 times a week
- e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

3. How often do you have six or more drinks on one occasion?

- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily



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The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Please choose one of the following :

(Fall screening)

1. In the following year have you fallen? Yes No
2. One fall with injury in the past year? Yes No
3. Two or more falls in the past year? Yes No
4. One fall without injury in the past year? Yes No
5. Two or more falls without injury in the past year? Yes No