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		

Over the past two weeks, how often have you been bothered by any of the following problems? (PHQ-2)

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
Little interest of pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Tobacco history

*Do you smoke now?*_____*Ever*?____*How much*?_____*If yes, packs per day*?_____

How much caffeine do you drink every day?_____*cups per day?*

(AUDIT C)

How often do you have a drink containing alcohol?

☐Never ☐Monthly ☐2-4 times per month ☐2-3 times a week ☐4 or more times a week

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

☐1 or 2 ☐3 or 4 ☐5 or 6 ☐7 to 9 ☐10 or more

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

☐Never ☐Less than monthly ☐ Monthly ☐Weekly ☐Daily or almost daily

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During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Yes ☐ No Comments:

During the past 4 weeks, have you experienced bodily pain in general?

☐Yes ☐No Comments:

During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you got sick and had to stay in bed, needed some help with daily chores, or needed help just taking care of yourself?

☐Yes ☐No Comments:

In the past 7 days, did you exercise for at least 3 of them?

☐*Yes* ☐No Comments:

On days when you exercised, for how long (in minutes)?_____minutes per day

Can you get places out of walking distance without help? ☐Yes ☐No

Can you shop for groceries or clothes without help? ☐Yes ☐No

Can you prepare your own meals? ☐Yes ☐No

Can you do your own housework without help? ☐Yes ☐No

Can you handle your own money without help? ☐ Yes ☐No

Do you need help eating, bathing, dressing, or getting around your home? ☐Yes ☐No

During the past 4 weeks, would you consider yourself in good health?

☐Yes ☐ No Comments:

In the past 4 weeks, would you say things have been going well for you?

☐Yes ☐No Comments:

Are you having difficulties driving your car?

☐Yes ☐No Comments:

Do you always fasten your seatbelt when you are in a car?

☐Yes ☐No Comments:

How often during the past 4 weeks have you been bothered by any of the following problems?

Fall or dizzy when standing up	☐Yes	☐No
Sexual problems	☐*Yes*	☐No
Trouble eating well	☐Yes	☐No
Teeth or dentures	☐Yes	☐No
Hearing or problems using the telephone	☐Yes	☐No
Tired or fatigued	☐Yes	☐No

Are you taking your medications the way you were instructed to?

☐Yes ☐No Comments:

Are you confident that you can control and manage most of your health problems?

☐Yes ☐No Comments:

Is stress a problem for you in handling things such as your health, your finances, your family, social relationships, or your work?

☐Yes ☐No Comments:

In the past 2 weeks have you felt nervous, anxious, or on edge?

☐Yes ☐No Comments:

In the past 2 weeks, were you not able to stop worrying or control your worrying?

☐Yes ☐No Comments:

How many hours of sleep do you usually get?_____hours

Do you snore or has anyone told you that you snore? ☐Yes ☐No

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

Have you received the home safety checklist today? ☐Yes ☐ No

For diabetic patients only:

Have you had a retinal eye exam in the past year? Yes_____No____If yes, by whom? _____

Have you ever had Congestive Heart Failure or water in the lungs? *Yes_____No* _____

If Yes, When was your last echocardiogram and where was it performed? _____

Please list any other current physicians and their specialty:

Physician: (ie: First, Last)	City Office is Located in:	Specialty:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

BEACON HEALTH PARTNERS

Home Safety Check List

Safety Concerns	Creating a Safe Environment
When you walk through a room, do you have to walk around furniture?	☐ Ask someone to move furniture so your path is clear
Do you have throw rugs on the floor?	☐ Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.
Do you have to walk over or around wires or cords (like lamps, telephones, or extension cords)?	☐ Coil or tape cords and wires to the wall so you can't trip over them.
Do you have any steps that are broken or uneven?	☐Call to have loose or uneven steps repaired.
Are you missing a light/or are any lights out of order over your stairways?	☐ Have a friend or family replace any missing lightbulbs or call an electrician to have a light placed at the top and bottom of the stairs.
Are any handrails loose or broken? Is there a handrail on only one side of the stairs?	☐ Fix any loose handrails or have new ones put on ensuring they are on both sides of the staircases.
Are there things you use often in your kitchen that are on high shelves?	☐ Move frequently used items into your lower kitchen cabinets keeping them at waist level if possible.
Is your step stool unsteady?	☐If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.
Do you need some support when you get in and out of the tub or up from the	☐ Install grab bars inside the tub and next to the toilet. There are also toilet

toilet?	seat raisers available for purchase as well as self-stick strips that be placed on the floor of the tub or shower.
Is the light near the bed hard to reach?	☐ Place a lamp close to bed where it is within arm's reach.
Is the path from your bed to the bathroom dark?	☐ Put in a night-light so you can see where you are walking. Some night-lights go on by themselves after dark.

Additional Tips to Prevent Falls

☐Exercise regularly to improve your balance and coordination as long as your doctor tells you this is ok.

☐Have your doctor or pharmacist look at all the medicines you take even the over-the-counter medicines. Some medicines can make you sleepy or dizzy.

☐Have your vision checked at least once per year by an eye doctor. Poor vision can increase your risk of falling.

☐Get up slowly after you sit or lie down.

☐Wear shoes both inside and outside of the house. Avoid going barefoot or wearing slippers.

☐Improve the lighting in your home. Put in brighter light bulbs; florescent bulbs are bright and cost less to use.

☐It's safest to have uniform lighting in a room. Hang lightweight curtains or shades to reduce glare.

☐Keep emergency numbers in large print near each phone.

☐Put a phone near the floor in case you fall and can't get up.

☐Think about wearing an alarm device that will bring help in case you fall and can't get up.

Adapted from CDC Check For Safety: A home Fall Prevention Checklist for Older Adults
http://wwwn.cdc.gov/pubs/COCInfoOnDemand.aspx?ProgramID=147