

NAME: _____

Today's Visit

What are you hoping to accomplish today? _____

Is there anything you'd like to work on to improve your health?

If you have one of the following conditions, please answer:

Diabetes: Any problems with medications? _____ Home glucose readings _____

High Blood Pressure: Any problems with meds? _____ Home BP readings _____

High Cholesterol: Any problems with meds? _____

Depression: Any problems with meds? _____ Any suicidal thoughts? _____

Do you have any trouble taking your medications? _____

Do you stop breathing during sleep or have concerns about sleep apnea? _____

Depression Screen: Over the last two weeks have you been bothered by little interest or pleasure in doing things or feeling down depressed or hopeless? _____

Between Visits

Have you been to the **ER, hospital or another doctor** since last seen here? _____

Please explain: _____

Lifestyle

Exercise: What do you do? _____ how long? _____ how often? _____

30 minutes walking most days can reduce the risk of a heart attack by 30%.

Smoking: How much do you smoke? _____ Are you interesting in quitting? _____

It is recommended that you stop smoking. We have a smoking cessation class for your assistance.

Alcohol:

How many drinking days do you have per week? _____

On average how many drinks per drinking day? _____

Have you had more than 4 drinks in a day in the past 3 months? _____

Are you or others concerned about your drinking? _____

Men who drink 5 or more drinks in a day or 15 or more drinks/week are at risk of a drinking problem; Women who drink 4 or more drinks in a day or 8 or more drinks/week are at risk

Falls: Have you fallen in the past year? _____

Do you have problems with walking or balance? _____

Safety: Are you in a relationship where you feel unsafe or have been hurt? _____

Do you regularly wear a seatbelt? _____

HIV Testing: Would you like HIV testing? _____

(If yes, please tell the nurse.) HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease, history of injection drug use; sex workers, sexual partners of HIV-infected persons or persons at risk.

Caffeine: How much caffeine per day? (i.e. coffee, tea, chocolate, pop) _____

Birth control method if applicable) _____

PLEASE SEE REVERSE SIDE

Update

Has anything, new come up in your **family history**? (new illness among blood relatives)_____

Have you developed any new drug **allergies**? _____

Are you experiencing any of the following?

Constitutional symptoms: fever, weight loss, extreme fatigue

Eyes: double vision, sudden loss of vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitations

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools

Genitourinary: irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, impotence

Skin: rash, changing mole

Sleep: snoring; difficulty sleeping

Neurological: headache, persistent weakness or numbness on one side of the body, falling

Musculoskeletal: joint pain, muscle weakness

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Allergic: hayfever

Please identify any issues above which are new or that you specifically want to address.