**HEALTH HISTORY PAGE ONE**

|  |  |  |
| --- | --- | --- |
| **NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_ | **VISIT DATE:** \_\_\_\_\_\_ |

I am - Right Handed Left Handed  Ambidextrous

**Do you have any of the following:**

**Allergies Chronic kidney disease Diabetes Gastroesophageal reflux**

**Anxiety Congestive heart failure Enlarged Prostate Glaucoma**

**Arthritis COPD High Blood PressureStroke/TIA**

**Atrial Fibrillation Coronary artery disease High Cholesterol**

**Asthma Depression Hypothyroidism**

**Cancer, What type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all surgeries:**

**Procedure Date Procedure Date**

**Cardiac ablation** \_\_\_\_\_\_\_\_ **Pacemaker/ICD implant** \_\_\_\_\_\_\_\_

**Coronary artery stent** \_\_\_\_\_\_\_\_ **Septoplasty/Sinus Surgery** \_\_\_\_\_\_\_\_

**Gastric Bypass \_\_\_\_\_\_\_\_\_\_ Tonsillectomy** \_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Other:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Do you have any ALLERGIES to medications? Please describe the reaction you had to the medication and the name of the medication:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I GIVE PERMISSION TO DOWNLOAD PRESCRIPTION MEDICATION HISTORY  YES OR  NO**

**If YES, you need to only list non-prescription items as noted. If NO, list everything.**

**List MEDICATIONS with DOSAGE & FREQUENCY, Include over-the-counter medicines, vitamins, & herbal supplements:**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** | ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **2.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **4.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **5.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **6.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **7.** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **8.** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **9.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **10.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **11.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **12.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **13.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **14.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **15.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **16.** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Marital Status:** Never Married Married Divorced Separated Widowed Significant Other

**Tobacco Use:** Cigarettes Cigars Pipe Vape Chewing Tobacco

**Never Smoked/Chewed**

**When did you quit smoking/chewing?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How old were you when you started smoking/chewing?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much do/did you smoke/chew per day?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous or current illicit drug use?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_

**HEALTH HISTORY PAGE TWO**

|  |  |  |
| --- | --- | --- |
| **NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_ | **VISIT DATE:** \_\_\_\_\_\_\_\_\_ |

**Do you drink alcohol?  YES  NO If yes, how many drinks do you consume per day?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Highest education level achieved:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is/was our occupation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Retired?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

|  |  |  |
| --- | --- | --- |
|  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Member of Family | Alive | Year of Birth | Deceased | Year of Death | Illnesses and/or Cause of Death |
| Father |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sister |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sister |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sister |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sister |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child - Female |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child - Female |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child- Female |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child- Female |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child-Male |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child-Male |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child-Male |  | \_\_\_\_\_ |  | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child-Male |  | \_\_\_\_\_ |  | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient's Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** | ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of Birth:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**EPWORTH SLEEPINESS SCALE**

How likely are you to doze off or fall asleep in the following situations? Use the following scale to rate the likeliness of falling asleep.

|  |  |
| --- | --- |
| Would never doze | 0 |
| Slight chance of dozing | 1 |
| Moderate change of dozing | 2 |
| High Chance of dozing | 3 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 0 | 1 | 2 | 3 |
| Sitting and reading |  |  |  |  |
| Watching television |  |  |  |  |
| Sitting inactive in a public place (movie theatre) |  |  |  |  |
| As a car passenger for an hour without a break |  |  |  |  |
| Lying down to rest in the afternoon |  |  |  |  |
| Sitting and talking to someone |  |  |  |  |
| Sitting quietly after lunch without alcohol |  |  |  |  |
| In a car while stopping for a few minutes in traffic |  |  |  |  |

**TOTAL SCORE:** \_\_\_\_\_

(Office will Score)

|  |  |
| --- | --- |
| **PATIENT'S INITIALS:** | \_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **DATE COMPLETED:** | \_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of Birth:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PHQ-9 (DEPRESSION SCREENING)**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | More | Nearly |
|  |  | Several | than half | every |
|  | Not at all | Days | the days | day |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself, or that you are a failure or have left yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 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 more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or hurting yourself in some way | 0 | 1 | 2 | 3 |
|  |  |  |  |  |
| **FOR OFFICE TO SCORE** |  |  |  |  |
| **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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient/Guardian Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_ |

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Przier Inc. No permission required to reproduce, translate, display, or distribute.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of Birth:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FALLS SCREENING QUESTIONNAIRE**

|  |  |  |
| --- | --- | --- |
| Have you fallen since your last visit? | Yes | No |
| If yes, how many times did you fall? | **\_\_\_\_\_** |  |
| Did your fall/s result in any injury? | Yes | No |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient's Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |