Name:

DOB:

What are your priorities for your visit today?

_____

_____

Preferred Pharmacy: _____

Do you have an Advanced Directive: Yes No

How often have you been bothered by the below symptoms over the last two weeks?

Little interest or pleasure in doing things in the last 2 weeks? *Please circle*

Not at all Several days More than half the days Nearly every day

Feeling down, depressed, or hopeless in the last 2 weeks? *Please circle*

Not at all Several day More than half the days Nearly every day

Do you have any NEW allergies?

_____

_____

Do you have any NEW medications

_____

_____

Did you receive the flu vaccine in the prior flu season? Yes No

Did you receive the flu vaccine this current flu season? Yes No

When was your last Colonoscopy? _____

Where was it completed? _____

When was your last mammogram? _____

Where was it completed? _____

When was your last Cervical Cancer Screening? _____

Where was it completed? _____

Social History

(For pediatric patients, please mark yes or no if there has been exposure in the household to below items)

Category	Yes	No	Usage
Tobacco			
Vaping			
Alcohol			
Substance			

Fall Risk Assessment ***(Only answer if you are 65 years or older)***

Are you 65 years or older?	Yes	No
Have you had any falls within the past year?	Yes	No
Have you had a fall with injury?	Yes	No
Do you have a fear of falling?	Yes	No
Do you feel unsteady when standing or walking?	Yes	No

Please answer if you are 65 years or older

Have you ever received a Pneumonia vaccine? Yes No

If yes, was it less than 5 years ago? Yes No

Any new surgeries or procedures since your last wellness visit? _____

_____

Please check yes or no if you've experienced any of these symptoms in the last month

1. Constitutional:

	YES	NO
Weight Gain		
Weight Loss		
Fever		
Fatigue		
Chills		
Night Sweats		
Hot Flashes		

2. Eyes:

	YES	NO
Eye pain		
Vision disturbance		
Dry eyes		
Watery eyes		
Periorbital Swelling	N/A	N/A
Itchy Eyes		

3. Ears, Nose, Mouth, Throat:

	YES	NO
Ear pain		
Nosebleeds		
Hearing Loss		
Hoarseness		
Ringing in ears		
Sore throat		
Mouth sore		
Drainage		
Congestion		
Difficulty swallowing		
Dental pain		

4. Musculoskeletal:

	Yes	No
Back pain		
Neck pain		
Joints swelling/stiffness/pain		
Extremity pain		
Decreased Range of Motion		
Muscle Pain		
Unable to bear weight		
Muscle Spasms/Cramps		

5. Respiratory/Lungs

	YES	NO
Shortness of breath		
Asthma		
Sleep Apnea		
Productive cough		
Non-Productive cough		
Wheezing		
Cyanosis (blue in the lips or fingers)		
Snoring		
Daytime Drowsiness		

6. Neurological:

	Yes	No
Numbness or tingling		
Headaches		
Loss of balance		
Trouble with speech		
Forgetfulness/confusion		
Syncope/Fainting		
Weakness		
Dizziness		
Loss of consciousness		
Tremors		
Seizures		
Double vision		

7. Cardiovascular:

	YES	NO
Chest pain/tightness		
Irregular rapid heart beat		
Palpitations		
Varicose Veins		
Swelling in legs/arms		
Shortness of breath while laying down		

8. Integumentary:

	Yes	No
Rash		
Change in skin color		
Itching		
Lesions		
Breast Pain/Lumps/Discharge		
Changes in moles		
Sun sensitivity		
Dry skin/nails/lips		
Non-healing sores		
Problems with scarring		
Subcutaneous Nodules	N/A	N/A
HX of blistering sunburn	N/A	N/A

9. GI:

	Yes	No
Black/Bloody stools		
Abdominal pain		
Nausea/Vomiting		
Heartburn/acid		
Constipation		
Loss of appetite		
Use of laxatives		
Cramping		
Diarrhea		
Rectal bleeding		

10. Psych/Social:

	Yes	No
Hallucinations		
Behavioral changes		
Depression		
Suicidal ideations		
Self-Harm		
Anxiety		

11. GU:

	Yes	No
Frequent Urination		
Urinary Urgency		
Frequent urination at night		
Painful urination		
Blood in urine		
Testicular pain		
Pelvic pain		
Abnormal urine smell/color		
Abnormal menstruation		
Burning		
Menopause		
Pain during intercourse		
Weak urinary stream		
Urinary Retention		
Proteinuria	N/A	N/A
Incontinence		

12. Hematologic/Lymph:

	Yes	No
Bleeding easily		
Swollen glands		
Delayed healing		
Bruising		
Swollen lymph nodes		
Anemia		

13. Allergy/Immunologic:

	Yes	No
Food allergy		
Environmental Allergy		
Medication allergy		
Hay fever		
Hives		
Immune disorders		

14. Endocrine:

	Yes	No
Decreased appetite		
Increased appetite		
Heat/Cold intolerance		
Increased thirst		
Increased sweating		