

Please check any of the following that you have experienced recently:

Constitutional

- ☐ Fever/chills
- ☐ Night sweats
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Fatigue/feeling tired

Eyes

- ☐ (circle)painful, red, watery, dry
- ☐ Change or loss of vision
- ☐ Eye disease/injury

Ears, Nose, Throat

- ☐ Loss or change in hearing
- ☐ Ear pain or discharge(circle)
- ☐ Frequent nosebleeds
- ☐ Frequent stuffy nose/sinuses
- ☐ Sore throat/dry mouth
- ☐ Painful teeth/bleeding gums
- ☐ Mouth ulcers
- ☐ Ringing in ears

Cardiovascular

- ☐ Chest pain with exerting yourself or even at rest
- ☐ Arm pain on exertion
- ☐ Shortness of breath when walking
- ☐ Shortness of breath when lying down
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Light-headed on standing
- ☐ Frequent ankle swelling

Respiratory

- ☐ Frequent cough
- ☐ Frequent wheezing
- ☐ Frequently short of breath
- ☐ Cough up blood
- ☐ Loud snoring, gasping or stop breathing while asleep

Gastrointestinal

- ☐ Abdomen or stomach pains
- ☐ Frequent nausea / vomiting
- ☐ Frequent constipation
- ☐ Change in appetite
- ☐ Frequent diarrhea
- ☐ Red blood in stools or black, tar-like stools
- ☐ Frequent diarrhea
- ☐ Vomiting blood
- ☐ Indigestion/fullness
- ☐ Frequent heartburn or reflux

Genitourinary

- ☐ Loss of control of urination
- ☐ Difficulty urinating
- ☐ Frequent urge to urinate
- ☐ Blood in urine
- ☐ Incomplete emptying

Women

- ☐ Unusual discharge from vagina
- ☐ Pain with sex
- ☐ Monthly periods: (circle)
Regular / Not regular / Painful / Absent
Heavy / > 5 days / Spotting
- ☐ Date of most recent period:
____/____/____

Men

- ☐ Discharge from penis
- ☐ Erections painful or difficult
- ☐ Lump in testicles/scrotum

Musculoskeletal

- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Joints often painful: (circle)
Shoulder / Elbow / Wrist / Hand
Hip / Knee / Ankle
- ☐ Frequent/daily back pain
- ☐ Swelling in extremities
- ☐ Frequent/daily neck pain
- ☐ Difficulty walking
- ☐ Muscle cramps
- ☐ Osteoporosis/fractures

Skin and Breasts

- ☐ Changing/growing mole (location): _____
- ☐ Jaundice
- ☐ Rash (location): _____
- ☐ Cuts: _____
- ☐ Sore that does not heal
- ☐ Change in hair/nails
- ☐ Dry, peeling, cracking skin
- ☐ Change in skin color
- ☐ (circle)Breast pain, lump, or nipple discharge. Left or Right

Neurological

- ☐ Loss of consciousness
- ☐ Weakness in a body part
- ☐ Frequent numbness/tingling in a body part
- ☐ Seizures
- ☐ Dizziness
- ☐ Frequent headaches/migraines
- ☐ Tremors
- ☐ Change in walking pattern
- ☐ Loss of feeling

Falls Assessment

Have you had 2 or more falls in the past 12 months? ☐Y ☐No
Falls with injuries? ☐Y ☐No

Psychiatric

Please answer yes or no to the following:

In the past month have you:

- ☐Y ☐N Often been bothered by feeling down, depressed, or hopeless?
- ☐Y ☐N Often been bothered by little interest or pleasure in doing things?
- ☐Y ☐N Uncomfortable nervous feelings or panic attacks

When was the last time you had more than 4-5 drinks in one day?

- ☐ Never
- ☐ Less than 3 months
- ☐ More than 3 months ago

- ☐ Been hit, kicked, punched, or otherwise hurt by some-one in the past year: ☐Y ☐N
- ☐ Feel safe in your current relationship? ☐Y ☐N
- ☐ Partner from a previous relationship is making you feel unsafe now: ☐Y ☐N

Endocrine

- ☐ Fatigue
- ☐ Recent increase in thirst
- ☐ Hair loss or increased hairiness
- ☐ Not able to tolerate heat or cold

Hematologic/Lymphatic

- ☐ Enlarged or painful glands: (circle) neck / armpit / groin
- ☐ Easy bruising / bleeding (circle)
- ☐ Anemia
- ☐ Frequent nosebleeds

Allergic/Immunologic

- ☐ Runny nose
- ☐ Frequent ear/sinus/chest infection
- ☐ Frequent itching or hives
- ☐ Frequent sneezing
- ☐ Sensitivity to foods, pets, etc.
- ☐ Exposed to HIV/AIDS, Tuberculosis, hepatitis BorC

Do you currently smoke?

- ☐ Yes ☐ No ☐ Former Smoker

PHQ9 & GAD7
Patient Name:

| Over the <u>last 2 weeks</u> , On how many days have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly everyday |
|--|----------------------|--------------------|-------------------------|---------------------|
| 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 you 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 |
| Total: | | | | |
| If you have 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 at all Difficult | Somewhat Difficult | Very Difficult | Extremely Difficult |

| Over the <u>last 2 weeks</u> , On how many days have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly everyday |
|--|----------------------|--------------------|-------------------------|---------------------|
| 1. Feeling Nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to control or stop worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| Total: | | | | |
| If you have 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 at all Difficult | Somewhat Difficult | Very Difficult | Extremely Difficult |