PRIME HealthCare, PC

Physical Exam History

*Office:*_____

All Patients: Please complete pages 1, 2 & 3 and SIGN page 3

Last Name	First Name	Date of Birth	Today's Date

Circle the number of years of formal education you have completed

<8	8	9	10	11	12	13	14	15	16	>16

Please circle the term best describes your current employment status and describe.

Employed	Describe:
Retired	Previous Job:
Unemployed	Previous Job:
Student	Where?

Please state in one or two sentences any current concerns you have.

Please list all previous operations with approximate dates. Circle* None *if applicable.

1. **None**	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please check the boxes next to all illness you have or have had.

☐ Atrial Fibrillation	☐ Asthma	☐ Crohn's Disease	☐ Esophagitis	☐ Excessive Alcohol Use
☐ Angina Pectoris	☐ Tuberculosis	☐ Ulcerative Colitis	☐ Anemia	☐ Drug Abuse
☐ Artificial Heart Valve	☐ HIV/AIDS	☐ Liver Cirrhosis	☐ Latex Allergy	☐ Depression
☐ High Blood Pressure	☐ Diabetes	☐ Hepatitis	☐ Cancer: Colon	☐ Anxiety
☐ Pacemaker	☐ Osteoporosis	☐ Gallstones	☐ Cancer: Stomach	☐ Suicide Attempt
☐ High Cholesterol	☐ Thyroid Disorder	☐ Lactose Intolerance	☐ Cancer: Pancreas	☐ Stroke
☐ Heart Attack	☐ Colon Polyps	☐ Pancreatitis	☐ Cancer: Prostate	☐ Migraine Headache
☐ Bleeding Disorder	☐ Irritable Bowel	☐ Diverticulosis	☐ Cancer: Esophagus	☐ Endometriosis
☐ Emphysema	☐ Ulcers	☐ Sprue	☐ Cancer: Breast	☐ Arthritis
☐ Eating Disorders	☐ Sexually Transmitted Disease		☐ History of Physical or Emotional Abuse	

List any other illnesses. Circle* None *if applicable.

1. **None**	4.
2.	5.
3.	6.

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Last Name	*First Name*

Please indicate whether you experience these symptoms. Circle yes or no.

Symptoms			Physician's Comments
Lack of Energy	Yes	No	**Constitutional**
Trouble Sleeping	Yes	No	
Weight Loss (10 lbs in 1 year)	Yes	No	
Weight Gain (10 lbs in 1 year)	Yes	No	
Fevers	Yes	No	
Hard or Infrequent Bowel Movements	Yes	No	**GI**
Loose or Frequent Bowel Movements	Yes	No	
Blood in Bowel Movements	Yes	No	
Vomit Blood	Yes	No	
Indigestion/Heartburn	Yes	No	
Food Sticks When Swallowing	Yes	No	
Painful Swallowing	Yes	No	
Yellow Jaundice	Yes	No	
Chest Pain	Yes	No	**Cardiovascular**
Palpitations/Irregular Heartbeat	Yes	No	
Swollen Legs	Yes	No	
Fainting	Yes	No	
Shortness of Breath	Yes	No	**Respiratory**
Asthma	Yes	No	
Wheezing/Coughing	Yes	No	
Cough	Yes	No	
Coughing up Blood	Yes	No	
Frequent Urination	Yes	No	**GU**
Blood in Urine	Yes	No	
Difficulty Urinating/Incontinence	Yes	No	
Could you be Pregnant?	Yes	No	
Problem with Menses	Yes	No	
Joint Swelling	Yes	No	**Musculoskeletal**
Joint Redness	Yes	No	
Muscle Aches	Yes	No	
Breast Lump	Yes	No	**Breast/Skin**
Skin Problems/Unusual or New Rash	Yes	No	
Localized Weakness	Yes	No	**Neuro**
Visual Changes	Yes	No	
Seizures	Yes	No	
Headaches	Yes	No	
Falls	Yes	No	
Loss of Memory	Yes	No	**Psychological**
Depression/Suicide Attempts	Yes	No	
Do you feel safe in current relationship?	Yes	No	
Hallucinations	Yes	No	
Anxiety	Yes	No	
Hot/Cold Intolerance	Yes	No	**Endocrine**
Excessive Thirst	Yes	No	
Bleeding	Yes	No	**Hemo**
Easy Bruising	Yes	No	
Allergy to Shellfish	Yes	No	**Allergy**
Allergy to X-Ray Dye	Yes	No	

Patient Signature: _____ ***Date:*** _____

The Patient Health Questionnaire
Nine-symptom Checklist

Name_____ Date_____

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 – 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: Total Score)	____	____	____	____

If you have experienced any of these problems, how difficult have they 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

Fall Risk Screening

1. Have you had two or more falls in the past year? ☐ Yes ☐ No
2. Are you being seen today for a recent fall? ☐ Yes ☐ No
3. Do you have difficulty with walking or balance? ☐ Yes ☐ No

For Physician: MINI COG EVALUATION

PRIME HealthCare, PC

HIPAA PATIENT CALLING INFORMATION

Name:_____ Date of Birth:_____

With whom do you allow us to share your personal medical information?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

How may we contact you?

Please list in the order the way you wish to be contacted. (1-3)

____ **Home Phone**:_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

____ **Work Phone**:_____

_____ DO NOT leave a message
_____ Leave brief message, return #
_____ May leave a detailed message

____ **Cell Phone:**_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

If you would like to communicate with our office via email, we encourage you to sign up for MyCare. This is a secure web portal. You can do this by going to www.stfranciscare.org/mycare . There is also an app on Googleplay or the App Store called My Chart.

**I understand that it is my responsibility to notify the office of any changes in my calling or HIPAA communication information.

PATIENT SIGNATURE_____ **DATE**_____