Preventive and Problem Visits

Important information about charges and payments

If you are expecting to have a fully covered wellness exam only, please bring this to the attention of your practitioner at the beginning of your visit.
We practitioners often deal with, and patients often ask us to address, chronic or new problems while they are here for their preventive care/wellness visits. Usually most patients don't want to come back for another visit if their problems can be addressed while they are in the office.
In that case, we must charge for a wellness exam and a diagnostic exam on the same visit and patients must pay any co-pays or deductibles due for the diagnostic exam charge. Insurance policies require this. If the practitioner does not have time to deal with all the problems you bring up then they will ask you to schedule another visit.
We do our best to address all your needs while you are here but **if you do not want any charges for a diagnostic exam you must tell the practitioner at the beginning of your visit to only deal with preventive care** so they are aware of your wishes. If you have any chronic problems and/or identified symptoms that need attention the practitioner will then ask you to schedule a separate appointment at another time so as to limit the charges to just a wellness visit.

NAME ______ date of birth ______ age ______ date of appointment ______

In order for us to provide you with effective medical care, we need to update some basic information about your past and present health. We also need to ask about your lifestyle because it affects your physical and emotional well being. The questions on the next pages cover the topics we will discuss. Please answer them as best you can. Mark an X on the line following the word "No" or"Yes" when either describes your symptoms or history. Use a question mark when you don't understand a question or aren't sure of your answer. Thank you for completing this form

Before you start, please list all questions you have for the doctor: ______

______

______

Since your last visit have you had urgent care or a change in health? no ____ yes ____

If yes, what was it? ______

______

______

Has there been a change in the health of your mother, father, sisters, brothers, spouse, or children? no ____ yes ____

What was the change? ______

______

______

Please list all the medicines, tonics, and over-the-counter medicines, vitamins and supplements you take: (use a separate sheet if needed)

Name	strength	how often	for what

please bring all your bottles of medication to each appointment

Do you have any allergies to medications? Please list them and describe your reaction: ______

Which is your dominant side? (which hand do you write with?) Right Left

During the past year, have you:

#	Question	no	yes
1	had frequent headaches?	no ____	yes ____
2	felt dizzy, fainted or had blackouts?	no ____	yes ____
3	had seizures or convulsions?	no ____	yes ____
4	noticed any lumps on your body or swollen glands	no ____	yes ____
5	had eye trouble?	no ____	yes ____
6	had difficulty hearing?	no ____	yes ____
7	had troubles with your ears?	no ____	yes ____
8	had dental or other mouth problems?	no ____	yes ____
9	suffered from nose bleeds?	no ____	yes ____
10	suffered from allergies or hay fever?	no ____	yes ____
11	noticed any hoarseness in your voice?	no ____	yes ____
12	been wheezing or been short of breath?	no ____	yes ____
13	had strange, persistent odors or tastes?	no ____	yes ____
14	frequently been coughing?	no ____	yes ____
15	sweated more than usual or had "night sweats"?	no ____	yes ____
16	had a racing heart or palpitations?	no ____	yes ____
17	had tightness or pains in your chest?	no ____	yes ____
18	had swollen feet or ankles?	no	yes

During the past year, have you had:

#	Question	no	yes
19	heartburn or indigestion?	no	yes
20	abdominal discomfort or pain?	no	yes
21	bouts of nausea or vomiting?	no	yes
22	difficulty swallowing?	no	yes
23	pains in your rectum?	no	yes
24	bowel movements that were bloody or tarry?	no	yes
25	any change in your bowel habits?	no	yes
26	If you are over 50, have you ever had sigmoidoscopy or Colonoscopy? If yes, when?	no	yes
27	frequent urination during the day or at night?	no	yes
28	uncomfortable or difficult urination?	no	yes

For Men Only: During the past year, have you:

#	Question	no	yes
29	had a drip or discharge from your penis?	no ____	yes ____
30	noticed lumps or swellings on your testicles?	no ____	yes ____
31	had difficulty with your erection?	no ____	yes ____

NAME date of birth Appointment date

For Women Only:

32 When was your last menstrual period?
33 Was it normal? no ____
34 number of days between periods
35 Length of bleeding, in days
36 If you are past menopause, have you had vaginal bleeding? no ____ yes ____
If you are past your meonpause, please skip to question 39
37 Has there been any change in your periods? no ____ yes ____
38 Have you noticed bleeding between your periods? no ____ yes ____
39 Do you have discomfort during intercourse? no ____ yes ____
40 Do you bleed from your vagina after intercourse? no ____ yes ____
41 Do you have any vaginal itching, burning or discharge? no ____ yes ____
42 - discomfort or pain in your pelvis? no ____ yes ____
43 - problems with your breasts? no ____ yes ____
44 When was your last Pap test? ____
45 Where was it done? ____
46 Have you ever had an abnormal Pap test? no ____ yes ____
47 Have you ever had an abnormal mammogram? no ____ yes ____
48 Date of last mammogram:
49 Where was it done?

For Both Men and Women, During the past year have you:

50 had any skin problems or noticed any changes in your skin or glands? no ____ yes ____
51 Do you use sunscreen routinely? yes ____ no ____
52 had aching muscles or joints? no ____ yes ____
53 had leg cramps? no ____ yes ____

Eating, Drinking, and Environmental:

54 Do you use salt at the table? no ____ yes ____
55 Has your appetite noticeably changed in the past month? no ____ yes ____
56 Have you gained/lost 10 or more pounds in the past 6 months? no ____ yes ____
57 Do you drink caffeinated coffee, tea or soda? no ____ yes ____
How much?
58 Do you smoke or use tobacco now? no ____ yes ____
59 If you stopped some time ago, when was it? no ____ yes ____
60 Are you or have you used prescription drugs without having a prescription no ____ yes ____
- ever used "recreational" drugs? no ____ yes ____
61 What is the age of your home?
62 Has your home been tested for radon? no yes
63 Have your pets been vaccinated for rabies? yes ____ no ____
64 Do you have a Living Will and Health Care Proxy filed with us? yes ____ no ____

Work and Play:

65 Are you generally satisfied with your work? yes ____ no ____
66 What kinds of exercise do you do?
67 What are your hobbies or leisure activities?
68 In what kinds of groups, organization,
69 or community activities do you participate?
70 List the countries that you have visited
71 in the past 6 months
72 Do you usually wear safety belts when riding in a car? yes ____ no ____
73 Are there any guns in your house? no ____ yes ____
What type?
Are they locked up? yes ____ no ____
74 Are there smoke detectors in your house? yes ____ no ____

Sexuality:

75 Are you sexually active now? yes ____ no ____
76 Are you generally satisfied with sex? yes ____ no ____
77 What do you do for family planning
78 or birth control?
79 Do you have sexual concerns? no ____ yes ____
80 In the last 5 years how many sexual partners have your had?
81 Would you like an HIV test? no ____ yes ____
82 Do you use or have contact with anyone who uses IV drugs? no ____ yes ____

Family Apgar Assessment

"Family" here refers to the relatives or close friends with whom you usually live or look to for continuing emotional support.
Are you satisfied with the way your family:
83 - helps you when you are in trouble? yes ____ no ____
84 - discusses things and shares your problems? yes ____ no ____
85 - accepts your new interests or changes in your lifestyle? yes ____ no ____
86 - expresses affection and responds to your feelings or moods? yes ____ no ____
87 - spends time together with you? yes ____ no ____
88 Are you concerned about physical violence or possible incest in your family? no ____ yes ____

Social Support

89 Is your time well balanced between your work, family, and leisure activities? yes ____ no ____
90 Is your relationship with your friends as good as it was last year? yes ____ no ____
91 Is your relationship with your spouse/partner as good as it was last year? yes ____ no ____
92 Is there someone with whom you can always discuss your personal problems? yes ____ no ____
93 Would you like patient education on any topics? no ____ yes ____
What topics?
94 Do you ever feel unsafe at home? yes ____ no ____
95 Has anyone at home hit or tried to injure you in any way? yes ____ no ____

Dryden Family Medicine
PHQ-9 + CAGE-AID

	Patient Name Date					
	PHQ-9					
	Over the Past 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 asleep, 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're 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 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	
	Column Totals					
	Add totals together					
10	If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other	Not difficult at all	Some-what Difficult	Very Difficult	Extremely Difficult	

	CAGE-AID				**NO**	**YES**
1	Have you ever felt you ought to cut down on your drinking or drug use?					
2	Have people annoyed you by criticizing your drinking or drug use?					
3	Have you felt bad or guilty about your drinking or drug use?					
4	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?					
	Total					

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol/drug problems.
A total score of two or greater is considered clinically significant