NAME **DATE OF BIRTH** **AGE** **APPOINTMENT DATE**

In order for us to provide you with effective medical care, we need to update some basic information about your past and present health. 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.

Please remember to put your name and date of birth on all pages. 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 ____

if 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:

1 had any falls? no ____ yes ____
2 had frequent headaches? no ____ yes ____
3 felt dizzy, fainted or had blackouts? no ____ yes ____
4 had seizures or convulsions? no ____ yes ____
5 noticed any lumps on your body or swollen glands? no ____ yes ____
6 had eye trouble? no ____ yes ____
7 had difficulty hearing? no ____ yes ____
8 had troubles with your ears? no ____ yes ____

NAME **DATE OF BIRTH**

9	had dental or other mouth problems?	no	yes
10	suffered from nose bleeds?	no	yes
11	suffered from allergies or hay fever?	no	yes
12	noticed any hoarseness in your voice?	no	yes
13	been wheezing or been short of breath?	no	yes
14	had strange, persistent odors or tastes?	no	yes
15	frequently been coughing?	no	yes
16	sweated more than usual or had "night sweats"?	no	yes
17	had a racing heart or palpitations?	no	yes
18	had tightness or pains in your chest?	no	yes
19	had swollen feet or ankles?	no	yes
	During the past year, have you had:		
20	heartburn or indigestion?	no	yes
21	abdominal discomfort or pain?	no	yes
22	bouts of nausea or vomiting?	no	yes
23	difficulty swallowing?	no	yes
24	pains in your rectum?	no	yes
25	bowel movements that were bloody or tarry (dark red or black in color)?	no	yes
26	any change in your bowel habits?	no	yes
27	If you are over 50, have you ever had screening for colon cancer?	no	yes
	If yes, What Test? When? Where?		
28	frequent urination during the day or at night?	no	yes
29	uncomfortable or difficult urination?	no	yes
	If Applicable: During the past year, have you:		
30	had a drip or discharge from your penis?	no	yes
31	noticed lumps or swellings on your testicles?	no	yes
32	had difficulty with your erection?	no	yes
	If you have a Vagina please answer questions 33 - 49		
	If you are past your menopause, please skip to question 39		
33	When was your last menstrual period?		
34	Was it normal?	yes	no
35	Number of days between periods		
36	Length of bleeding, in days		
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? Was it normal?	yes	no
46	Have you ever had an abnormal Pap test?	no	yes

NAME **DATE OF BIRTH**

47 Have you ever had a mammogram? no ____ yes ____
Date of last mammogram:
48 Where was it done?
49 Was it normal? yes ____ no ____
Do you have any 1st or 2nd degree relatives who have had breast &/or ovarian cancer?
If yes , please list relationship to you,type of cancer, & at what age were they diagnosed no ____ yes ____

For People Aged 50-64:

50 As an adult, have you had a fracture from relatively mild trauma? no ____ yes ____
51 Did either of your parents have a hip fracture? no ____ yes ____
52 Do you smoke? no ____ yes ____
53 Have you been on prednisone or other 'steroid' medication in the past? no ____ yes ____
54 Have you ever been diagnosed with Rheumatoid Arthritis? no ____ yes ____
55 On average, do you have 3 or more servings of alcohol per day? no ____ yes ____
56 Have you ever had any of the following (if yes, please circle any that apply): no ____ yes ____
Type 1 Diabetes, osteogenesis imperfecta, hyperthyroidism, hypogonadism,
menopause prior to age 45, chronic liver disease, malabsorption or chronic malnutrition?

For Everyone, During the past year have you:

57 had any skin problems or noticed any changes in your skin or glands? yes ____ no ____
58 had aching muscles or joints? no ____ yes ____
59 had leg cramps? no ____ yes ____
60 Do you use sunscreen routinely? no ____ yes ____

Eating, Drinking, and Environmental:

61 Have you gained/lost 10 or more pounds in the past 6 months? no ____ yes ____
62 Do you drink caffeinated coffee, tea or soda? no ____ yes ____
63 On average how much caffeinated coffee, tea or soda do you drink per day?
64 On average how much non-caffeinated soda do you drink per day?
65 On average how much Juice do you drink per day?
66 On average, how many servings of Fruits and Vegetables do you eat per day?
67 Do you smoke or use tobacco products now? no ____ yes ____
68 If you smoke, how many years have you been smoking?
69 On average, over the years, how much have you smoked per day?
70 If you don't smoke, have you quit in the last 15 years? no ____ yes ____
71 If you stopped some time ago, when was it?
72 Are you or have you used prescription drugs without having a prescription? no ____ yes ____
73 Are you or have you ever used "recreational" drugs? no ____ yes ____
74 Have your pets been vaccinated for rabies? yes ____ no ____
75 Do you have a Living Will and Health Care Proxy filed with us? yes ____ no ____

NAME **DATE OF BIRTH**

Work and Play:

76 Are you generally satisfied with your work? yes ____ no ____

77 What kinds of exercise do you do?

78 What are your hobbies or leisure activities?

79 In what kinds of groups, organization, or community activities do you participate?

79 List the countries that you have visited in the past 6 months

80 Do you usually wear safety belts when riding in a car? yes ____ no ____

81 Are there smoke detectors in your house that work? yes ____ no ____

Sexuality:

82 Are you sexually active now? yes ____ no ____

83 Are you generally satisfied with sex? yes ____ no ____

84 What do you do for family planning or birth control?

85 Do you have sexual concerns? no ____ yes ____

86 In the last year how many sexual partners have your had?

87 Have you had a new sexual partner since your last STD test? ____

88 Are you involved in a non-monogamous relationship ____

89 Would you like an HIV test? no ____ yes ____

90 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:

91 - helps you when you are in trouble? yes ____ no ____

92 - discusses things and shares your problems? yes ____ no ____

93 - accepts your new interests or changes in your lifestyle? yes ____ no ____

94 - expresses affection and responds to your feelings or moods? yes ____ no ____

95 - spends time together with you? yes ____ no ____

96 Are you concerned about physical violence or possible incest in your family? no ____ yes ____

Social Support

97 Is your time well balanced between your work, family, and leisure activities? yes ____ no ____

98 Is your relationship with your friends as good as it was last year? yes ____ no ____

99 Is your relationship with your spouse/partner as good as it was last year? yes ____ no ____

100 Is there someone with whom you can always discuss your personal problems? yes ____ no ____

101 Do you ever feel unsafe at home? yes ____ no ____

102 Has anyone at home hit or tried to injure you in any way? yes ____ no ____

103 Would you like patient education on any topics? no ____ yes ____

104 What topics?

Dryden Family Medicine
PHQ-9 + CAGE-AID

	Patient Name	Date of Birth		Today's 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				
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 people?	Not difficult at all	Some-what Difficult	Very Difficult	Extremely Difficult

For Office Use Only:	***Total Score:***
Results of 5 or greater:	*Results of 9 or greater - todo to repeat in 10 months*
Positive:	
Situational:	See Progress note:
Re-assess next visit:	Medication:
Referral:	Other:
Initial:	
Date:	

	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)?			
5	How many times have you had more than 5 drinks a day, in the past year?			
		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

rev 11/2021

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.