Name:		DOB:	BAYVIEW
Date:		Age:	
		Sex:	
Facility:			

Annual Wellness Visit: Patient Medical History Update

If any of your medical history has changed, please fill out the following before your scheduled appointment.

Any new allergies: ☐ Yes ☐ No **If yes, please list:** _____

Any new medications: ☐ Yes ☐ No **If yes, please list:** _____

Have you visited any new specialists since you last visited with the physician your scheduled with today? If so, please provide the reason.

☐ Yes ☐ No **Name of Physician:** _____ **Specialty:** _____

Reason for Visit: _____

Have you had any other tests ordered by other physicians since you last visited with the physician your scheduled with today? If so, please provide the name of the physician that ordered the test and provide the reason why.

☐ Yes ☐ No **Name of Physician:** _____

Tests Ordered: _____

Reason for Visit: _____

Any updates to your family history since you last visited? ☐ Yes ☐ No

If yes, please explain. _____

Any updates to your social habits since you last visited? For example, changes to your living arrangements, marital status, smoking, alcohol consumption, etc.

☐ Yes ☐ No

If yes, please explain. _____

Please list any other medical update information you would like to provide:

Please provide a list of all providers currently involved in your medical care (include names such as other physicians, therapists, DME providers, home health care providers) or Select ☐ None if there aren't any: _____

Name:		DOB:	BAYVIEW
Date:		Age:	
		Sex:	
Facility:			

Patient Health Questionnaire (PHQ-9)

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 - or 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 TV	**0**	**1**	**2**	**3**
8 Moving or speaking so slowing 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**
	Add Columns:	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

10 If you 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 difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.

INSTRUCTIONS FOR USE

FOR DOCTOR OR HEALTHCARE PROFESSIONAL USE ONLY

PHQ-9 Quick Depression Assessment

For initial diagnosis:

1 Patient completes PHQ-9 Quick Depression Assessment.

2 If there are at least 4 check marks in the gray highlighted section (including question #1 and #2), consider a depressive disorder. Add score to determine severity.

3 Consider Major Depressive Disorder
- if there are at least 5 check marks in the gray highlighted section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2 to 4 check marks in the gray highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1 Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2 Add up marks by column. For every mark: Several days = 1, More than half the days = 2, Nearly every day = 3

3 Add together column scores to get a TOTAL score.

4 Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.

5 Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring - add up all checked boxes on PHQ-9

For every mark:
Not at all = 0
Several Days = 1
More than half the days = 2
Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal Depression
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
20-27	Severe Depression

Name:		DOB:	BAYVIEW
Date:		Age:	
		Sex:	
Facility:			

Pre-Office Visit

TODAY'S VISIT:

What are you hoping to accomplish today? _____

_____

_____

Is there anything you'd like to work on to improve your health? _____

_____

IF you have one of the following conditions, please answer:

Diabetes: Any problems with medications? _____ If on Insulin, any change in dose? _____
Fasting blood sugars ranges: lowest _____ highest _____ average sugar _____
Blood sugar 2 hrs after meals: _____ Last eye exam date: _____ Last podiatry exam: _____
High Blood Pressure: Any problems with meds? _____ Home BP readings: _____
High Cholesterol: Any problems with meds? _____
Depression/Anxiety: Any problems with meds? _____ Any suicidal thoughts? _____
Seeing therapist? _____ If so, who? _____ Last seen? _____

Problems taking any of your medications? _____
Medication changes since last office visit? NEW meds w/ doses: _____
_____ Meds stopped: _____
Recent Lab/Diagnostic Tests: Date of last labs: _____
Diagnostic Tests done since last visit: _____
Do you stop breathing during sleep or have concerns about sleep apnea? _____
Depression Screen: Over the last 2 weeks, have you been bothered by little interest or pleasure in doing things or feeling down, depressed, or hopeless? _____

LIFESTYLE: _____ Check if no change since last form

Exercise: What do you do? _____ How long? _____ How often? _____
*****30 minutes walking most days can reduce the risk of a heart attack by 30%.*****

Smoking: How many per day? _____ Are you interested in quitting? _____
It is recommended that you stop smoking. Some people are able to quit with the help of 1-800-QUITNOW (1-800-784-8669).
What have you tried in the past to quit? _____

Alcohol: How many drinking days do you have per week? _____
On average, how many drinks per drinking day? _____
Have you had more than 4 drinks in a day in the past 3 months? _____
Are you or others concerned about your drinking? _____
Men who drink 5 or more drinks in a day or 15 or more drinks/week are a risk of a drinking problem. Women who drink 4 or more drinks in a day or 8 or more drinks/week are at risk.

Falls: Have you fallen in the past year? _____
Do you have problems with walking or balance? _____

Safety: Are you in a relationship where you feel unsafe or have been hurt? _____
Do you regularly wear a seatbelt? _____

HIV Testing: Would you like HIV testing? *(If yes, please tell nurse)* _____
The CDC recommends routine screenings for everyone age 13-64 years of age, regardless of risk factors. Risk for HIV infection increases in persons with a history of sexually transmitted disease, injection drug use, sex workers, sexual partners of HIV-infected persons or high risk persons.

Caffeine: How much per day? (i.e., coffee, tea, chocolate, soda) _____

Calcium/Vitamin D Supplements: Dose _____
It is recommended you take Calcium 600 mg w/ Vitamin D 400 IU one tab in the AM, one in PM, w/ food for better absorption & less constipation.

Birth Control Method (if applicable): _____

0	DOB: 0	DOS: 0

UPDATE:

Has anything **NEW** come up in your **FAMILY HISTORY**? (new illness among blood relatives): _____

Have you developed any new **drug/food allergies**? _____

Have you been to the **ER, hospital,** or **another doctor/specialist** since last visit? _____

Please explain: _____

HEALTH MAINTENANCE:

If you are here for your annual physical, please give approximate date of last exam for:

Pap Smear _____
Mammogram _____
Bone Density _____
PSA (Prostate Specific Antigen) _____
Colonoscopy _____ (GI Doctor: _____)
Eye Exam _____
Dental Exam _____
Any abnormal findings on these exams? _____
Use sunscreen? _____
Changed fire alarm/carbon monoxide detector batteries? _____

RECENTLY, have you been experiencing any of the following? Please circle: ___Check if no change since last time

General: Fever Chills Night Sweats Unexplained Weight Loss Weight Gain Extreme Fatigue Dizziness

Eyes: Double Vision Sudden Loss of Vision Eye Pain Eye Discharge

Ears, Nose, Mouth, Throat: Ear Pain Ringing in Ears Hearing Loss Runny Nose Nose Bleeds
Nasal Congestion Sinus Pain Sore Throat Voice Hoarseness Mouth Ulcers Dental Pain
Bleeding Gums Bad Breath Use Dentures Jaw Pain

Cardiovascular: Chest Pain Palpitations Shortness of Breath with Walking/Exercise
Sleep on more than 2 pillows due to breathing problems Leg Swelling Pain in Legs with Exercise

Respiratory: Cough Wheezing Shortness of Breath Congestion Cyanosis/Turn Blue Require Oxygen

Gastrointestinal: Appetite Decrease/Increase Problems with or painful swallowing Nausea Vomiting
Constipation Diarrhea Blood in Stools Change in Stool Consistency Abdominal Pain Bloating
Acid Reflux Mass Hernia Hemorrhoids Rectal Pain Stool Incontinence Jaundice Dark Urine

Genitourinary: Frequent or painful urination Urgency to Urinate Bloody Urine
Urinate 2 or more times at night Urine Incontinence Decreased Libido STD Concerns
# of current sexual partners: _____ *Use condoms?* _____

Females: Vaginal Discharge Vaginal Itching Vaginal Dryness Heavy or Irregular Menstrual Cycles
Painful Menses Vaginal Bleeding after Menopause Pelvic Pain Bothersome Hot Flashes

Males: Decreased Urine Stream Dribbling Hesitancy to Urinate Pain/Swelling in Scrotum or Penis
Discharge from Penis Ulcers/Rash in Groin Impotence

Breast: Pain Mass Nipple Discharge History of Breast Disease Breast Implants
Do you do self-breast exams? _____ *Do you want to be taught self-breast exam?* _____

Musculoskeletal: Joint Pain or Swelling or Redness Joint Stiffness Muscle Pain Muscle Weakness
Problems w/ Walking Use Cane/Walker/Wheelchair Recent Injury

Neurological: Headache Persistent Weakness (Generalized or on 1 Side of the Body?)
Numbness or Tingling Paralysis Tremors Seizures Loss of Consciousness
Memory Problems Confusion Head Injury

Sleep: Snoring Difficulty Falling or Maintaining Sleep On CPAP Machine For Sleep Apnea

Psychiatric: Increased Stress Anxiety Panic Attacks Depression Mood Swings
Suicidal or Homicidal Thoughts Hallucinations Attention Problems Behavior Problems

Endocrine: Excessive thirst, hunger, or urination Cold or Heat Intolerance Throat Mass/Pain Tremor

Hematologic: Unusual Bruising or Bleeding Enlarged Lymph Nodes Blood Clots

Skin: Rash Changing Mole Excessive Dryness Acne Hair Loss or Excess

Allergic: Hay Fever/Allergic Rhinitis Receiving Allergy Shots Recent Use of Epipen

Please identify any issues above which are **NEW** or that you specifically want to address, and **NOT** addressed by any other physician/specialist.

Reviewed by Dr. _____

Name:		DOB:	
Chart:		Age:	
Date:		Sex:	

Facility:

Review of Systems

Please check all that apply to you.

General:			
☐ Weight loss/gain	☐ Increased thirst	☐ Use recreational drugs	☐
☐ Fatigue	☐ Insomnia	☐	☐
Head/Eyes/Ears/Nose/Throat:			
☐ Frequent Headaches	☐ Eye trouble	☐ Motion sickness	☐ Dentures
☐ Blurred vision	☐ Hearing loss	☐ Frequent sore throats	☐ Taste change
☐ See halos on lights	☐ Ringing in ears	☐ Hoarseness	☐ Congested/runny nose
☐ Double vision	☐ Frequent ear infections	☐ Bleeding gums	☐ Frequent nose bleeds
☐ Eye pain/itching	☐ Ear aches	☐ Toothache	☐
Neck:			
☐ Swelling/lump in neck	☐ Neck pain	☐	☐
Lungs:			
☐ Frequent cough	☐ Night sweats	☐ Cough up phlegm	☐
☐ Cough up blood	☐ Wheezing	☐ Sleep on several pillows	☐
☐ Frequent chest colds	☐ Short of breath easily	☐	☐
Heart and Vessels:			
☐ High blood pressure	☐ Dizzy spells	☐ Leg cramps	☐ Skipped heart beats
☐ Racing heart/palpitations	☐ Shortness of breath	☐ Heart murmur	☐
☐ Chest pain	☐ Swollen feet/ankles	☐ Phlebitis/blood clots	☐
Digestive:			
☐ Loss of appetite	☐ Abdominal pain	☐ Heartburn	☐
☐ Trouble swallowing	☐ Change in bowel habits	☐ Hemorrhoids	☐
☐ Nausea/vomiting	☐ Constipation/diarrhea	☐ Change in stool color	☐
Urinary:			
☐ Pain or burning with urination	☐ Frequent infections	☐ Blood in urine	☐
☐ Loss of control	☐ Change in color/odor	☐ Urinate times a night	☐
Male Genital:			
☐ Poor or weak stream of urine	☐ Prostate trouble	☐ Pain in testicles	☐
☐ Discharge	☐ Lump on testicles	☐ Problem with erections	☐
Female Genital:			
☐ Last period begin: _____	☐ Vaginal bleeding	☐ Breast soreness	☐
☐ Pain with sex	☐ Ovary/Uterus trouble	☐ Breast lumps	☐
☐ Loss of desire	☐ Vaginal discharge	☐	☐
Musculoskeletal:			
☐ Muscle aches	☐ Painful swollen joints	☐ Back pain	☐
Skin:			
☐ Rashes	☐ Itching	☐	☐
☐ Bruise/bleed easily	☐ Acne/pimples	☐	☐
Mood:			
☐ Anxiety/Nervousness	☐ Depression	☐ High stress	☐
☐ Crying spells	☐ Mood swings	☐ Poor concentration	☐
☐ Thoughts of suicide	☐ Sexual problems	☐	☐
Sleep:			
☐ Trouble going to sleep	☐ Excessive Daytime Fatigue	☐	☐
☐ Trouble keeping asleep	☐ Gasping at night	☐ Snoring	☐

Comments: